

MASSAGE THERAPY INTAKE FORM

Date: _____

Name: _____ Soc. Sec. #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Marital Status: Single Married Partnered

Children's Names and Ages: _____

Name of Spouse/Significant Other: _____

Preferred Appointment Day and Time: _____

Referred by: Patient or Dr.: _____ Yellow Pages Ad Sign/Location

Method of Payment: Cash/Check/Credit Health Insurance
 Auto (date of injury _____) L&I (date of injury _____)

What are your goals for treatment? _____

Present Symptoms: What is your major complaint or condition you want to improve? _____

What activities have you used to address this condition? _____

What activities aggravate the condition? _____

What activities improve the condition? _____

Are you under medical/therapeutic treatment? Yes No
If yes, for what condition? _____

Please list your care provider's name and number: _____

List any medications (including aspirin) and nutritional supplements you are taking: _____

Specify any known allergies: _____

Please list any additional comments regarding your general well-being: _____

Please mark signs and symptoms below using the following symbols: O – occasional F – frequent C – constant
 Leave blank if does not apply.

GENERAL SYMPTOMS

- headache
- chills
- fainting
- dizziness
- loss of sleep
- fatigue
- nervousness
- loss of weight

GASTRO-INTESTINAL

- poor appetite
- poor digestion
- nausea
- vomiting
- constipation
- diarrhea
- ulcers
- hemorrhoids

EAR, EYE, NOSE, THROAT

- ear ache
- ears ring/buzz
- blurred vision
- nose bleeds
- sore throat
- frequent colds
- sinus trouble

RESPIRATORY

- cough
- chest pain
- difficulty breathing

MUSCLE AND JOINTS

- stiff neck
- neck pain
- weakness or pain arms/hands/
legs/face (circle)
- numbness or pain arms/hands/
legs/face (circle)
- back pain: upper/lower
- swollen joints
- foot troubles
- pain between shoulders
- shoulder pain
- wrist pain/carpal tunnel
- elbow pain
- knee pain

CARDIO-VASCULAR

- high blood pressure
- low blood pressure
- strokes
- poor circulation
- swelling in ankles/legs

SKIN OR ALLERGIES

- rashes
- bruising easily
- dryness
- sensitive skin

GENITO-URINARY

- frequent urination
- inability to control
- urinary infection
- blood in urine
- bed wetting
- prostate problem
- pain on urination

HABITS

- smoking ___pks/day
- alcohol ___drinks/day
- coffee ___cups/day

FOR FEMALES ONLY

- painful periods
- irregular cycles
- hot flashes
- cramps
- Pregnant at this time: Yes No
- Last menstrual cycle _____

EXERCISE

- none
- moderate
- daily

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

- | | | | |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> appendicitis | <input type="checkbox"/> anemia | <input type="checkbox"/> heart disease | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> measles | <input type="checkbox"/> goiter | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> mumps | <input type="checkbox"/> influenza | <input type="checkbox"/> mental disorder |
| <input type="checkbox"/> polio | <input type="checkbox"/> chicken pox | <input type="checkbox"/> pleurisy | <input type="checkbox"/> stress (home) |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> diabetes | <input type="checkbox"/> alcoholism | <input type="checkbox"/> stress (work) |
| <input type="checkbox"/> whooping cough | <input type="checkbox"/> asthma | <input type="checkbox"/> venereal disease | Other _____ |

ADDITIONAL COMMENTS:

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by Jon Wall, Patrick Kendrick, Jennifer Jorgensen and/or Amy Dawson (massage therapists) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other purposes of massage specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I have received a copy of the massage therapist's policies and I understand them and agree to abide by them.

Tipping the massage therapists is welcomed and appreciated, but by no means expected.

Client Signature: _____ Date: _____

Consent to Treatment of a minor: _____ Date: _____