Massage Client Intake Form

PLEASE PRINT LEGIBLY

Name _____ Email _____

Address _____ City/State/Zip _____

Phone: Home _____Work _____Cell _____ Birthday ___/___/___

Occupation _____ Referred to This Office by _____

In Case of Emergency Please Contact: _____Phone_____

General and Medical Information

Y N Have you ever had a professional massage? If yes, how often?

Y N Are you pregnant? If yes, how far along are you?

Y N Are you sensitive to touch/pressure in any area?

Y N Are you allergic or sensitive to any oils (essential oils, nut oils, scents)? If yes, please list:

List of surgeries (type and date): _____

Indicate Areas of Pain/Tension:

What is your present complaint? _____

Date pain began: _____

On a scale from 1-10, 10=highest, rate your levels of pain ___/10

How did your symptoms begin? _____

_____

What have you done for relief? _____

What aggravates the condition? _____

Is the condition getting better/worse? _____

Are you taking any medication for pain relief? _____

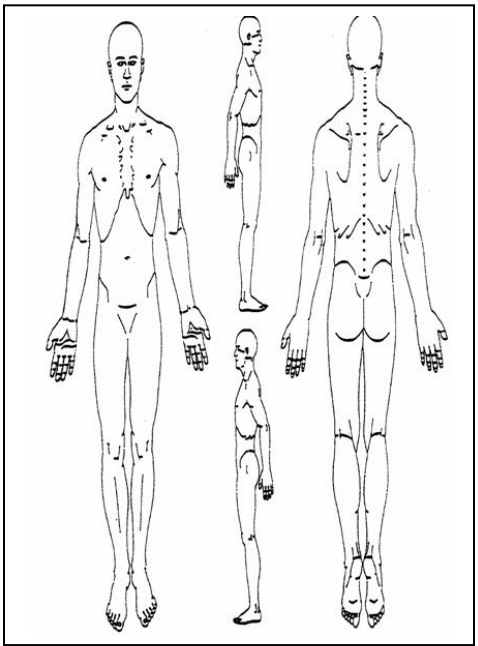
Analgesics ___ Anti-inflammatory ___ Other ____

How long have you been taking medication for pain relief? _____

List of current medications and reason: _____

Please check all that apply:

- Skin condition-rash, warts, hives, skin cancer, other _____
- Lymphatic condition-swollen gland, nasal congestion, lymph edema
- Joint problems/stiffness-arthritis – where _____
- Bone Condition-osteoporosis, fracture, other _____
- Headaches
- Recent injury or accident-whiplash, sprain, bruise, other _____
- Circulatory Condition-high blood pressure, varicose veins, blood clots
- Numbness/Tingling, Sciatica
- Tendonitis, Bursitis
- Diabetes



Please mark in the diagram where you have pain or discomfort

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Medical History

1. Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? (If yes, please explain.)

_____

_____

2. Have you ever had any surgeries? (If yes, please explain.) _____

_____

_____

3. Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, hypertension (high blood pressure), high cholesterol or diabetes? (If yes, please explain.) _____

_____

_____

4. Are you currently taking any medication (for other conditions than pain relief)? (If yes, please explain.)

_____

_____

General Lifestyle Information

1. What is your current occupation? _____

2. Does your occupation require extended periods of sitting? _____

3. Does your occupation require extended periods of repetitive movements? (If yes, please explain) ____

_____

4. Does your occupation require you to wear shoes with a heel (dress shoes)? _____

5. Does your occupation cause you anxiety (mental stress)? _____

6. Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.) _____

_____

_____

7. Do you have any hobbies (reading, gardening, working on cars, etc.)? (If yes, please explain.) _____

_____

_____