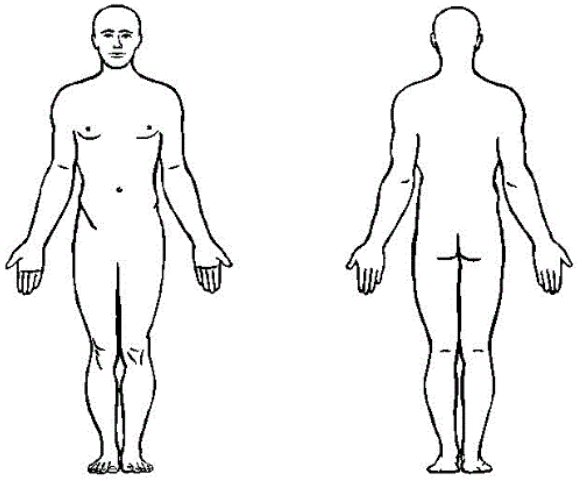
Massage Intake Form

Name:_____ Date:_____
Address:_____
DOB:_____Email:_____
Phone(Day:)_____(Night):_____
Emergency Contact:_____ Phone:_____
Date of injury:_____ Insurance ID:_____
Insured:____Self_____Spouse_____Other_____
Name of physician/source of referral:_____

List symptoms:_____
_____
Please show on the diagrams where you feel your symptoms:



Does anything help to relieve your symptoms?_____
_____
Does anything aggravate your symptoms?_____
What do you do for exercise and how often?_____
_____
Do you often feel stressed or anxious?_____ If so, what do you do to release your stress and anxiety?_____
_____

For the following, please put a "C" for current and/or a "P" for past if any of these conditions apply.

General: Headaches:_____Pain:_____Sleep disturbances:_____
Fatigue:_____Infectious:_____Fever:_____Sinus:_____
Skin Conditions: Rashes:_____Athlete's foot, warts:_____
Allergies: Scents, oils, lotions:_____Detergents:_____Other:_____
Muscles and joints: Rheumatoid arthritis:_____Osteoarthritis:_____
Osteoporosis:_____Scoliosis:_____Broken bones:_____
Spinal or disk problems:_____Lupus:_____TMJ, jaw pain:_____
Spasms, cramps:_____Sprains, strains, tendonitis, bursitis:_____
Joint problems:_____Neck, shoulder, arm, low back, hip, leg pain:_____
Nervous System: Head Injuries:_____Dizziness, ringing in ears:_____
Loss of memory:_____Numbness/tingling:_____Sciatica:_____
Chronic pain:_____Depression:_____Other:_____
Respiratory/cardiovascular: Heart disease, stroke, irregular heart beat:_____Chest Pain:_____Blood clots:_____High/low blood pressure:_____Swelling, poor circulation, varicose veins:_____
Asthma:_____
Digestive/Elimination System: Abdominal pain:_____Poor digestion:____
Poor elimination, irregular elimination:_____Other:_____
Endocrine System: Thyroid dysfunction:_____Diabetes:_____
Reproductive System: Pregnancy:_____Painful, emotional menses:_____Fibrotic cysts:_____Other:_____
Cancer/Tumors: Benign:_____Malignant:_____
Habits: Tobacco:_____Alcohol:_____Coffee/soda:_____Other:_____

Any further explanation for above information OR something else you think I should be aware of?_____
_____
_____

Contract for Care

I promise to participate fully in my health care, make choices that support my health and well-being, and let my practitioner know the effect of the treatments and exercises given.

I give my consent to receive treatment. I will inform my practitioner if I feel compromised or unsafe at any time.

I have provided all the information about my health history in good faith and will inform my practitioner of any changes.

Signature:_____Date:_____