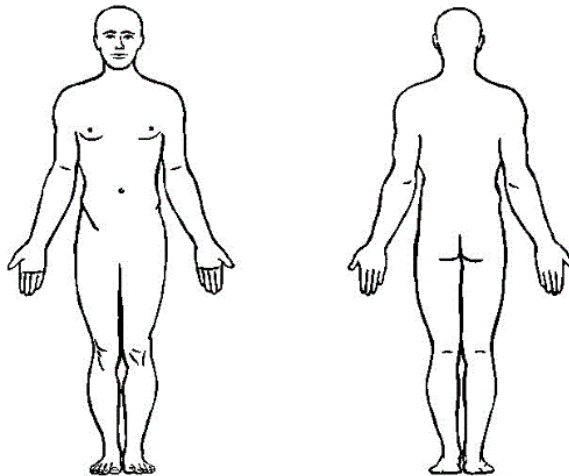


# Massage Intake Form

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:\_\_\_\_\_