

Message Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name _____ Date of birth _____

Address _____

State _____ City _____ Home Phone _____

Work Phone _____ Occupation _____

Have you ever received massage therapy? _____ Yes _____ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.) _____

Are you currently taking any medications? _____ Yes _____ No

If yes, please list name and reason for medications _____

Are you currently seeing a healthcare professional? _____ Yes _____ No

If yes, please list names and reason/treatment _____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

- | | |
|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> depression, panic disorder, other psych condition |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> diverticulitis |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> headaches |
| <input type="checkbox"/> broken/dislocated bones | <input type="checkbox"/> heart conditions |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> back problems |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> constipation/diarrhea | <input type="checkbox"/> muscle strain/sprain |
| <input type="checkbox"/> auto-immune condition* | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> hepatitis (A, B, C, other) | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> skin conditions | <input type="checkbox"/> seizures |
| <input type="checkbox"/> stroke | <input type="checkbox"/> whiplash |
| <input type="checkbox"/> surgery | <input type="checkbox"/> chemical dependency (alcohol, drugs) |
| <input type="checkbox"/> TMJ disorder | |

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share,

please do so: _____

Do you have any of the following today:

_____ skin rash _____ cold/flu _____ open cuts _____ severe pain
_____ anything contagious _____ injuries/bruises

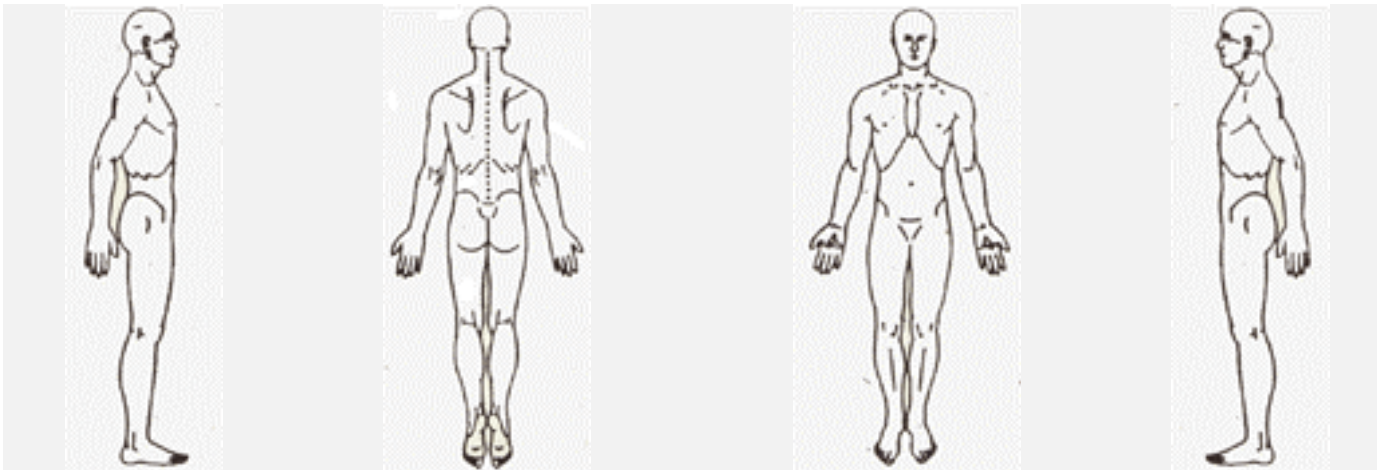
Do you have any allergies to:

_____ medications _____ foods (nuts, etc.)
_____ environmental allergens (dust, pollen, fragrances)
_____ reactions to skin care products

If any of the above are checked, please give details: _____

Are you wearing: _____ contact lenses _____ hearing aid _____ hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? _____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:
need to move or change position ❖ sighing, yawning, change in breathing
stomach gurgling ❖ emotional feelings and/or expression
movement of intestinal gas ❖ energy shifts ❖ falling asleep ❖ memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____ Date _____