apex BODYWORX massage & stretch therapy

Massage and Stretch Therapy Intake Form

Name: _____ Date: _____ Referred By: _____
Address: _____ Best Contact Phone Number: _____
City/State/Zip: _____ Occupation/Employer: _____
Birthday: _____ Email Address: _____

Massage and Stretch History

Have you ever received a professional massage?____Yes____No If yes, frequency: _____ Last Massage _____
What results do you want from your massage sessions? _____

_____

Desired Pressure: Light _____ Firm _____ Deep _____
Prioritize the areas of your body that you would prefer to be massaged. _____
Please check the areas of your body that you give permission to receive massage:
□ Back □ Legs □ Buttocks □ Arms □ abdomen □ Pecs/chest □ Neck □ Head □ face □ _____
List stress reduction and exercise activities. Include frequency. _____
How often do you stretch?_____Areas you feel are tightest in your body: _____

_____

Medical History

Please list any recent injuries, illnesses, or surgeries: _____

_____

Are you currently under the care of a physician? Yes_____ No_____
If yes, please explain. _____
List current medications, including aspirin, ibuprofen, etc. _____

_____

Please check all that apply

____ Cancer: Type _____	____ Hi/Low Blood Pressure	____ TMJ
____ Migraines/Headaches	____ Immovable Joints	____ Tendonitis
____ Back Problems	____ Cold Hands/Feet	____ Bruise Easily
____ Sciatica	____ Sinus Problems	____ Allergies
____ Osteoporosis	____ Neck Problems	____ Fibromyalgia
____ Diabetes	____ Arthritis/Bursitis	____ Carpal Tunnel

Do you have any chronic or frequent pain? _____
Are you pregnant?_____If yes, how far along are you? _____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the proper health care providers of my condition. I understand that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. If, for any reason cancellation is necessary, I will give a 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment unless it can be filled. Emergency cancellations will be determined by my therapist.

_____ _____
Signature Date

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