ADVANCED SOFT TISSUE THERAPYS, Inc. INTAKE FORM
1506 54TH AVE N Ste. 1
ST PETERSBURG, FL 33730 727-522-4263

Today's date_____Date of Birth_____

Last name_____ First name _____MI _____

Work phone _____ __Cell Phone_____

Home Phone_____Email_____

Mailing address_____

City_____State_____Zip_____

Person to contact in case of emergency_____Phone_____

Date of accident/injury_____ Referred by_____

What are your concerns or goals for this session? _____

_____

How long have you had this condition? _____

What activities make your pain worse_____

What have you done to get relief? _____

Physician's/Therapists who have treated this condition_____

What is the medical diagnosis_____

Do you exercise?_____ Do you stretch? _____ Are you pregnant?_____

What kind of pressure do you prefer for massage?_____

Have you had a professional massage within the past year?_____

Please circle any of the following that apply to your condition currently or during the past year.
Massage Therapy may be contraindicated unless prescribed because of some medical conditions

Muscle spasms in neck	Limited range of motion	Contagious/infectious disease
Tightness in shoulder muscle	Constipation Medications	Pain in shoulder (s)
Bladder trouble	Cancer	Pins and needles in hands/feet
Kidney trouble	Varicose veins	Headaches
Prostrate problems	Swollen/painful joints	Whiplash
Pains in legs and feet	Skin disorders	Dizziness
Chest pain	Ulcers	Numbness
Blood Clots/phlebitis	Bruising	Grating in neck
Low/high blood pressure	Difficulty breathing	Hernia
Cold feet or Cold hands	TB	Pinched nerve in back
Diabetes	Herniated or bulging disc	Broken Bones
Metal Implants or screws	Pacemaker	Injuries
Bruise Easily	Epilepsy	Seizures
Allergies	Back Pain	Frozen shoulder
Pregnancy	Contact lenses	Dentures

Other conditions:_____

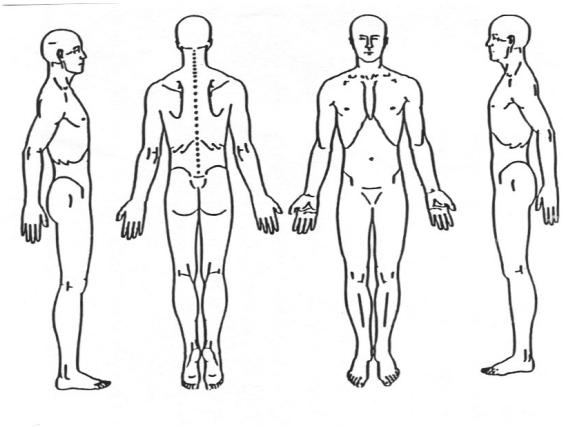
I understand that the massage therapy that I receive is provided for the purpose of relaxation and relief of muscular tension. Discomfort and pain can occur with massage therapy treatments. I agree to immediately inform the massage therapist should I experience any pain or discomfort during this session, or future sessions, so that the pressure and/or strokes may be adjusted to my level of comfort. I take full responsibility for any discomfort that may occur from the massage and will hold the massage therapist harmless for any discomfort or injury suffered. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe treatment for any physical or mental illness, and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand that massage therapy should not be performed when certain medical conditions exist, such as cancer, without physician approval. Therefore, I agree to keep the practitioner informed of my current medical condition.

I agree to give at least 24 hours notice to cancel an appointment. Should I fail to give this proper notice I agree to pay the full cost of the time booked.

Client Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize the massage therapist to administer massage therapy, to my child or dependent, as they deem necessary.

Signature of Parent or
Guardian_____Date_____



Please mark the area of discomfort or pain.