MASSAGE THERAPY INTAKE FORM

Today's date ____________________Work phone _______________________Home phone____________________

CELL PHONE____________________________________ Emergency Contact Person________________________

Last name_______________________________________ First name _________________________MI ________

E-mail Address____ Date of Birth_________________________

Mailing address____

City____State________________Zip__________________

Date of accident/injury________________________________ Referred by_________________________________

What are your concerns and goals for this session? ____

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How long have you had this condition? ____

What activities make your pain worse____

What have you done to get relief? ____

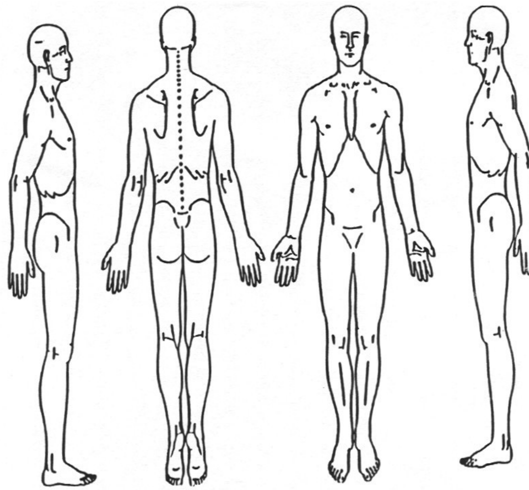
Physician's/Therapists who have treated this condition____

What is the medical diagnosis____

Do you exercise?____________ Do you stretch? ___________ Are you pregnant?___________________________

Check each of the following, which you currently experience.

Muscle spasms in neck	Limited range of motion	Contagious 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	Prostate problems	Swollen/painful joints
Whiplash	Pains in legs and feet	Skin disorders
Dizziness	Chest pain	Ulcers
Sciatica	Swollen ankles	Fractures
Numb hands or feet	Blood Clots/phlebitis	Bruising
Grating in neck	Low/high blood pressure	Shortness of breath
Hernia	Cold feet or Cold hands	TB
Pinched nerve in back	Diabetes	Herniated or bulging disc



PLEASE MARK THE AREAS OF PAIN OR DISCOMFORT ON THE IMAGE ABOVE

PLEASE READ, AGREE AND SIGN THE FOLLOWING:

I, ____________________________understand that the massage therapy that I receive is provided for the purpose of relaxation and/ or 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 alleged injury suffered. I furtherunderstand 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 without physician approval. When in doubt, please **consult a qualified medical professional.**

Therefore, I agree to keep the practitioner informed of my current and future medical condition(s)

I agree to give at least 24 hours notice to cancel an appointment. Should I fail to do this,
I agree to pay a $37.50 Cancellation fee. Failure to not pay this fee may result in not being able to book future appointments.

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_________________________________

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