Massage Therapy Confidential Intake Form

Name _____ Phone # _____
Address _____ City/State/Zip _____
Date of Birth _____

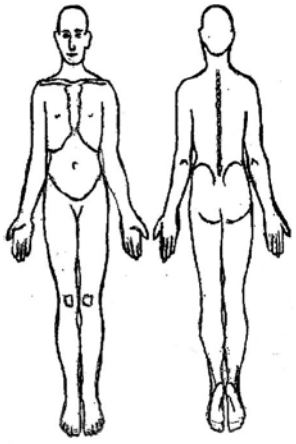
What are your goals for the treatment today? _____
_____
What is your occupation? _____
How many hours do you sleep each night? _____ Do you wake feeling rested? Y N
Sleeping position: _____
Are you pregnant? Y N How many weeks? _____
Do you have any allergies? _____
Are you currently under a physicians care? If so, for what? _____
Do you exercise? Y N Describe activities/frequency: _____
_____

Please circle any conditions that you are currently or have recently experienced:

Heart Conditions	Skin Irritation/Rash	Herniated Disc
Diabetes	Headaches	IBS/Intestinal Problems
Arthritis	Cancer	Depression/Anxiety
Blood Clots/DVT	Whiplash	Varicose Veins
Autoimmune Disorders	Tendinitis	Bursitis

Are there any other medical conditions I should be aware of? _____
Please list any recent or major injuries, accidents or surgeries: _____
Please list any medications you are currently taking: _____

Please mark the figures to the right noting the following:
Pain or Discomfort
Numbness or Tingling
Weakness
Swelling



On a scale of 0-10 (0 being no problems and 10 being severe problems) how would you rate the following?
Pain _____
Stress Level _____
Overall Health _____

I have informed my massage therapist of all medical conditions that I am aware of, including medications I am currently taking, and will update my practitioner of any future changes in my health status. I understand that massage is not a substitute for medical care, and is not intended to diagnose or treat any illness. I understand what my treatment involves and that there are some slight risks associated with massage therapy. I give my consent for a massage treatment. I understand that I will be charged for appointments that I cancel within 24 hours of the appointment.

Client's Signature _____ Date _____