TREAT Massage Therapy

Client Intake Form

Personal Information:

Name _____ Home Phone _____ Cell Phone _____

Address _____

City/State/Zip _____

E-mail _____

Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

Primary Physician _____ Address _____

The following information will be used to help plan safe and effective massage therapy sessions. Please answer the questi to the best of your knowledge.

1. Have you had a professional massage before? YES ☐ NO ☐

If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? YES ☐ NO ☐

If yes, please explain: _____

3. Are you wearing contact lenses ☐ dentures ☐ a hearing aid? ☐

4. Are you pregnant? YES ☐ NO ☐

5. Please describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

6. Are you currently in pain (acute or chronic) YES ☐ NO ☐

Please state the type of pain and indicate the exact location of your pain on the diagrams on the last two pages

Sharp ☐ Dull ☐ Shooting ☐ Throbbing ☐ Burning ☐ Aching ☐ Numbness ☐ Tingling ☐

7. When did you current symptoms appear? _____

8. Are you currently experiencing any of the following conditions?

Flu or Cold ☐ Inflammation ☐ Fever ☐ Infection ☐

9. Do you perform any repetitive movement in your work, sports, or hobby? YES ☐ NO ☐

If yes, please explain: _____

10. Do you sit for long hours at a workstation, computer or driving? YES ☐ NO ☐

If yes, please explain: _____

11. What do you expect from this therapeutic massage session?

_____

TREAT Massage Therapy

Medical Information:

12. Are you currently under medical supervision YES ☐ NO ☐

If yes, please explain: _____

13. Are you currently taking any medications, vitamins, herbs? YES ☐ NO ☐

If yes, please list all medications and their intended use:

Medication/Vitamin/Supplement	Used To Treat:	Prescribed by:

14. Please indicate if you have any of the following

MUSCULOSKELETAL
- ___ Fibromyalgia
- ___ Sprains/Strains
- ___ Osteoporosis
- ___ Gout
- ___ Osteoarthritis/RA
- ___ TMJ Dysfunction
- ___ Arthritis
- ___ Bursitis
- ___ Plantar Fascitis
- ___ Tendonitis
- ___ Torticollis
- ___ Whiplash Syndrome
- ___ Sciatica
- ___ Thoracic Outlet Syndrome
- ___ Chronic Headache

CIRCULATORY
- ___ Anemia
- ___ Hemophilia
- ___ High/Low Blood Pressure
- ___ Raynaud's Disease
- ___ Varicose Veins
- ___ Heart Condition
- ___ Blood Clots/Phlebitis
- ___ Diabetes I/II

DIGESTIVE
- ___ Irritable Bowel Syndrome
- ___ Colitis
- ___ Gallstones
- ___ Hepatitis
- ___ Crohn's Disease
- ___ Diarrhea/Indigestion

NERVOUS SYSTEM
- ___ ALS
- ___ Multiple Sclerosis
- ___ Parkinson's Disease
- ___ Bell's Palsy
- ___ Neuritis
- ___ Spinal Cord Injury
- ___ Stroke
- ___ Trigeminal Neuralgia
- ___ Seizure Disorders

RESPIRATORY
- ___ Pneumonia
- ___ Sinusitis
- ___ Asthma
- ___ Trouble Breathing
- ___ Dizziness

SKIN
- ___ Fungal Infections
- ___ Impetigo
- ___ Dermatitis/Eczema
- ___ Psoriasis
- ___ Rashes
- ___ Warts/Moles
- ___ Athletes Foot

OTHER
- ___ Seizure Disorders
- ___ Sleep Apnea
- ___ Anxiety/Panic Attacks
- ___ Cancer
- ___ HIV/AIDS
- ___ Lupus
- ___ Edema

15. If you have a condition that is not listed above, please use the space below.

_____

_____

The above is accurate and true to my best knowledge. I understand that massage therapists do not diagnose, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health.

Signature: _____ Date: _____