

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 questions 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? _____

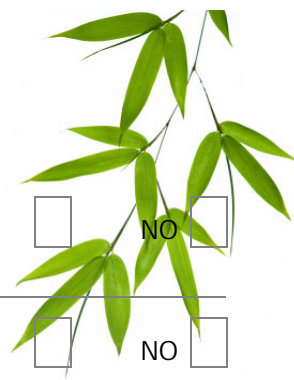
8. Are you currently experiencing any of the following conditions?
Flu or Cold Inflammation Fever Infection
9. Do you perform any repetitive movement in your work, sports, or hobby? YES NO

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?

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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

| <u>MUSCULOSKELETAL</u> | <u>CIRCULATORY</u> | <u>NERVOUS SYSTEM</u> | <u>SKIN</u> |
|---------------------------------------------------|---------------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Anemia | <input type="checkbox"/> ALS | <input type="checkbox"/> Fungal Infections |
| <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Impetigo |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Dermatitis/Eczema |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Osteoarthritis/RA | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> TMJ Dysfunction | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Warts/Moles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Clots/Phlebitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Athletes Foot |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Diabetes I/II | <input type="checkbox"/> Trigeminal Neuralgia | <u>OTHER</u> |
| <input type="checkbox"/> Plantar Fasciitis | <u>DIGESTIVE</u> | <input type="checkbox"/> Seizure Disorders | <input type="checkbox"/> Seizure Disorders |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Irritable Bowel Syndrome | <u>RESPIRATORY</u> | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Torticollis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anxiety/Panic Attacks |
| <input type="checkbox"/> Whiplash Syndrome | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Thoracic Outlet Syndrome | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Trouble Breathing | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> Diarrhea/Indigestion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> 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: _____