Massage Intake Form

Name: ____ Date of Birth: ________________

Where do you have pain? ____

Rate your Pain 1(none) to 10 (severe) ________________________________ Sex: Male Female

Why have you come for a massage? ____

Have you received massage before? Yes No

Describe any accidents, injuries or surgeries including dates:

____

Allergies to Lotions, Oils, Creams or Fragrances?: ____

Allergies to Medications? ____

Are you currently receiving any medical treatment? ____

Please list any medications you are taking: ____

Please check if you are currently experiencing any of the following?

- ______ Pregnancy
- ______ Flu or Cold, Fever or Infection
- ______ Disease or Inflammation
- _______ Injury Rash or Skin Condition: If so, where? ______________________________

HABITS

Exercise: ______________________________ Sleep Difficulties? Yes No Please describe: __________________

Where do you tend to hold stress in your body? ____

Where do you have any especially tender-to-touch areas? ____

Please answer the following questions and CIRCLE the conditions that apply to you:

Musculoskeletal: Broken bones / fractures? Yes No Where? ____________________ When? _________

Muscle Spasm? Yes No How is your Range of Motion Effected? ______________________________

Arthritis? Yes No Degenerative Rheumatoid Tendonitis Bursitis Carpel Tunnel _____________

Disc Problems? Yes No Sprains & Strains? Yes No Where? ____________________________

Head & Neck: STRESS? Yes No Injuries? ________ Whiplash? Yes No When? __________________

Headaches? Yes No Migraines Tension Sinus Stress ______________________________

High Blood Pressure Parkinson's Stroke Anxiety Depression Mental Condition

Neck Pain Hand or Arm numbness Tingling Bell's palsy Epilepsy Seizures _________________

Diseases: Cancer Anemia Lymphoma Lymphedema Tumors Heart Disease Diabetes Phlebitis

Varicose Veins Circulation problem Hepatitis HIV/AIDS Blood pathogens _________________

Respiratory: Asthma Allergies Sensitivity to Scents Cough Smoker Pneumonia Bronchitis Emphysema

Chew Tobacco

Digestion: Acid Reflux Daily BM Constipation Diarrhea IBS Diverticulitis Colitis Crohn's

Skin: Bruise Easy Edema Swollen Glands Rash Eczema Psoriasis Shingles Herpes Ringworm

Please read & sign the following: I acknowledge that the above information is complete and accurate.

Patient Signature ____ **Date:** ______________________________

Therapist Notes ____

____

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Therapist Signature ____

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