

**INTAKE FORM**

First Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Last Name \_\_\_\_\_

Referred by \_\_\_\_\_

Email Address \_\_\_\_\_

Mobile Phone # \_\_\_\_\_

Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Emergency contact name \_\_\_\_\_

Physician's name \_\_\_\_\_

Emergency contact relationship \_\_\_\_\_

Physician's phone # \_\_\_\_\_

Emergency phone # \_\_\_\_\_

Date of initial visit \_\_\_\_\_

How would you rate your general health?

- Excellent
- Good
- Fair
- Poor

Have you had a professional massage before?

- Yes (*Date of last treatment*) \_\_\_\_\_
- No

List current medications & the conditions they are treating

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any major accidents or surgeries (including dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please tell us about any allergies or hypersensitivities

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for initial visit

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEAD NECK**

- Headaches / migraines     Vertigo / dizziness
- Ringing in ears             Hearing loss
- Vision problems             Vision loss

**RESPIRATORY**

- Asthma                             Shortness of breath
- Chronic cough                 Bronchitis
- Emphysema                    Sinusitis
- Frequent colds                Smoker
- Family history of respiratory difficulties

**NERVOUS SYSTEM**

- Sensory loss / change     Numbness / tingling
- Sciatica                         Epilepsy
- Seizures                         Multiple sclerosis

**MUSCULOSKELETAL SYSTEM**

- Arthritis                         Family history of arthritis
- Osteoporosis                  Tendonitis
- Bursitis                          Jaw pain (TMJ)
- Pins / plates / wires / artificial joint

**REPRODUCTIVE**

- Pregnant                         Given birth
- Gynecological problems

**CARDIOVASCULAR**

- High blood pressure         Low blood pressure
- Heart attack                  Stroke
- Heart disease                 Poor circulation
- Phlebitis / varicose veins  Pacemaker
- Hemophilia
- Chronic congestive heart failure
- Family history of cardiovascular problems

**SKIN & INFECTIONS**

- Hepatitis                        HIV / AIDS
- Herpes                          Tuberculosis
- Lyme disease                 Infectious skin conditions

**OTHER CONDITIONS**

- Cancer                          Diabetes
- Unexplained weight loss  Digestive conditions
- Fibromyalgia                  Chronic fatigue syndrome
- Depression                    Anxiety
- Psychiatric disorder
- Other conditions \_\_\_\_\_

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It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_