MASSAGE THERAPY - INITIAL VISIT INTAKE FORM

FULL NAME:_____ DOB: _____

MAILING ADDRESS: _____

EMAIL ADDRESS:_____ PHONE NUMBER: _____

OCCUPATION: _____

YOUR PRIMARY CONCERN TODAY:_____

OTHER AREAS OF CONCERN: _____

DISCOMFORT LEVEL: MILD _____ MODERATE _____ INTENSE _____

DURATION: CONSTANT _____ INTERMITTENT _____ WITH CERTAIN MOTIONS _____

WHEN/HOW DID PAIN OR DISCOMFORT BEGIN:_____

WHAT ACTIVITIES ARE PAINFUL TO DO? _____

RELATED TO A WORK INJURY OR MOTOR VEHICLE ACCIDENT? YES ____ NO_____

ARE YOU CURRENTLY UNDER THE CARE OF A HEALTHCARE PROVIDER FOR ANY REASON? YES_____ NO_____ IF YES, NAME/PHONE NUMBER: _____

IS THERE A MEDICAL DIAGNOSIS FOR YOUR CURRENT CONCERN? YES_____ NO_____
PLEASE EXPLAIN: _____

FREQUENT ACTIVITIES/EXERCISE: _____

ALL PREVIOUS INJURIES, INCLUDING BROKEN BONES NOT REQUIRING SURGERY:

_____

_____

LIST ALL PREVIOUS SURGERIES WITH APPROXIMATE DATES::

_____

_____

LIST ALL MEDICATIONS (INCLUDING SUPPLEMENTS) YOU ARE CURRENTLY TAKING:

_____

_____

PLEASE CIRCLE ANY ILLNESSES/MEDICAL CONDITIONS YOU HAVE CURRENTLY OR HAVE EVER PREVIOUSLY HAD:

RESPIRATORY: Asthma Bronchitis Emphysema Shortness of Breath Chronic Cough

CARDIOVASCULAR: Blood Clots High Blood Pressure Low Blood Pressure Stroke Varicose Veins Heart Attack Congestive Heart Failure Syncope Lymphedema Cold Hands/Feet Pacemaker Thrombosis/Embolism

SKIN: Bruise Easily Hypersensitivity Melanoma Skin Condition/Disorder

HEAD & NECK: Ear Problems Headaches Hearing Loss Jaw Pain (TMJD) Migraines Sinus Problems Vision Loss Vision Problems

INFECTIOUS CONDITIONS: Athlete's Foot Hepatitis Herpes Respiratory Conditions HIV Skin Conditions Cold/Flu Fever Shingles

REPRODUCTIVE: Gynecological Conditions Pregnancy

NEUROLOGICAL: Loss of Balance Burning Tingling Cerebral Palsy Numbness Multiple Sclerosis Stabbing Pain Parkinsons Seizures

MISCELLANEOUS: Allergies Dizziness Mental Illness Fatigue Depression Anaphylaxis Cancer Hemophilia Surgical Pins/Wire Insomnia Crohn's Disease Epilepsy Osteoarthritis Rheumatoid Arthritis Artificial Joints Diabetes Fibromyalgia Loss of Sensation Osteoporosis Arthritis Digestive Conditions Gout Lupus Stress Scoliosis Painful Joints Ruptured/Herniated Disc Autoimmune Disorder Lymph node removal Other:_____

ARE YOU WEARING CONTACTS: YES _____ NO _____

ARE YOU ALLERGIC TO LATEX? YES _____ NO _____

PLEASE READ THE FOLLOWING & SIGN BELOW:

- I UNDERSTAND THIS MASSAGE IS NOT A REPLACEMENT FOR MEDICAL CARE AND THAT NO DIAGNOSIS WILL BE MADE.
- I UNDERSTAND THE INFORMATION PROVIDED ABOVE IS STRICTLY CONFIDENTIAL AND IS USED TO HELP THE LMT DETERMINE ANY INDICATIONS OR CONTRAINDICATIONS FOR MASSAGE.
- I GIVE PERMISSION FOR THE LMT TO DISCUSS INFORMATION PERTINENT TO MY CONDITION AND TREATMENT WITH MY OTHER HEALTHCARE PROVIDERS.
- I ACKNOWLEDGE THE CANCELATION/NO SHOW POLICY (ATTACHED).
- I HAVE SIGNED THE RELEASE OF LIABILITY WAIVER

CLIENT SIGNATURE: _____ DATE: _____

IN CASE OF EMERGENCY, CONTACT: _____

PHONE NUMBER: _____