

Massage Therapy Patient Intake Information

Name _____ Date _____

Address _____ City & State _____ Zip _____

Phone (Day) _____ (Evening) _____ Email _____

Date of Birth _____ Occupation _____

Insurance _____ Name of Insured _____ ID# _____

Referring Physician _____ Phone _____ Fax# _____

Physician's Address _____

Date of Injury/Onset _____ Due to an auto accident? (yes/no)

If yes: Insurance Company Name _____

Phone _____ Claim # _____

Emergency Contact _____ Relationship _____ Phone _____

Medications currently taking _____

Current Issues/concerns _____ Previous Massage Experience _____

Within the last 3-days, have you experienced any of the following conditions: (yes/no)

Flu or Cold Inflammation Fever Infection Contagious Disease

Is there any chance of pregnancy? (yes/no) Weeks? _____ Are you feeling well right now?(yes/no)

Please indicate if you have experienced any of these conditions:

- | | | | | |
|---------------------------------------|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Skin Disease/Rash |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Hematoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Surgery (any) |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Phlebitis/Clots | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fractures | <input type="checkbox"/> High/Low BP | <input type="checkbox"/> Postural Problems | <input type="checkbox"/> Wear Contacts |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Injury (any) | <input type="checkbox"/> Pressure sensitivity | <input type="checkbox"/> Whiplash |

Other important information (explain tension/pain areas) _____

Please read the following information and sign where indicated.

Some specific conditions may not benefit from massage/bodywork and may be contra-indicated. The therapist in attendance has the right to refuse massage/bodywork in the event she thinks it may be more harmful than beneficial for the client. The attending therapist may refer you to your primary care physician if required, for she is not qualified to make diagnosis or prescribe treatment for medical conditions.

I understand that the therapist is also not qualified to perform spinal or skeletal adjustments and that massage/bodywork is primarily on the soft tissue and is for the express purpose of relaxation and stress relief. I also understand that at any time during the session that I have the privilege as well as the obligation to inform the therapist of any pain or excessive pressure that causes me discomfort.

I understand that no illicit or sexually suggestive remarks or advances will be tolerated and that the session will end immediately in the event of such actions. I affirm that the above information is true and accurate to the best of my knowledge.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____