Massage and Bodywork Confidential Intake Form

Please complete this document as accurately as possible. Some questions may seem unrelated to your condition; however they play a role in your treatment plan.

Client Contact Information

Name:____

Address:____

City:_________________________________State:__________Zip Code:_____________

Home Ph:___________________Cell Ph:____________________ Wk Ph:__________________

Occupation:_________________________Employer_____________________________________

Age:_______ Birth Date_____/____/_____

*Email:____

Your email will never be given out to another party.

Emergency Contact Name and Number:____

Physician Information

Physician's Name:_____________________________Type of Physician_________________

Do I have permission to contact your healthcare provider if needed? ____yes ____no

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Current Medical Information

Are you currently under a doctor or health practitioner's care for any medical condition(s), illness or injury? No / Yes If so, please explain____

Is there any chance you are pregnant or are trying to conceive? No / Yes
If pregnant, how many weeks?_____ Any concerns or complications?_________________________

Do you wear contacts? No / Yes Dentures? No / Yes Hearing Aids? No / Yes Hair piece? No / Yes

Are you taking any pain relievers or anti-inflammatory meds? No / Yes
If yes, please list the medication and the time of your last dose_______________________________

Are you taking any blood thinning medications or medications that make you bruise easily? No / Yes
Please list your medications, vitamins, and/or supplements (dosage not required)
____
____

Please list ANY allergies you have to medications, food, lotions or oils:_______________________
____

MEDICAL HISTORY

All of this information is strictly confidential and cannot be shared with anyone by law. Please include any recent rashes, bruises, bumps, breaks, sprains, strains, fractures, illnesses or surgeries.

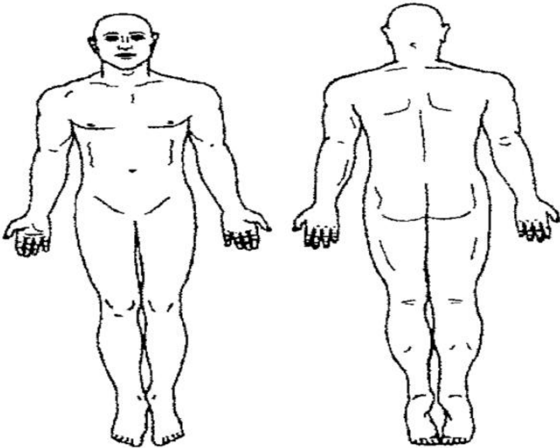
___Abscess/open sore/surgical site
___Allergies
___Arteriosclerosis
___Asthma
___Bruise easily
___Cancer/undiagnosed lump
Type________________________
Location_____________________
Treatment type(s)______________
Lymph nodes removed or treated
___Depression
___Diabetes
___Digestive problems i.e., IBS, reflux
___Epilepsy
___Fibromyalgia
___Fibrosis
___Fluid Retention
___Headaches
___Heart Conditions
___Herniated/ruptured disc
___Hepatitis
___Herpes
___History of mental illness
Physical or emotional abuse, counseling/therapy
___HIV/AIDS
___Hypertension
___Inner ear problems
___Insomnia
___Other (including past injuries that still affect you)
___Implants
Where?_____________
___Lupus
___Phlebitis
___PMS / cycle difficulty
___Pregnancy (current)
___Post Traumatic Stress
___Osteoarthritis
___Osteoporosis
___Rheumatoid arthritis
___Skin sensitivity
___Sleep apnea
___ Varicose veins
___ Vision problems

Have you ever had a massage before? No / YES

What are your current symptoms/issues?____

What treatments have you received for your symptoms?______________________________________

Please mark your areas of focus: Are there any areas that you want avoided during your massage?



Here are some abbreviation letters you can use to mark the areas:

X = area of focus today
N = numbness
T = tingling
B = burning
A = aching
S = sharp
I = injury site

Any additional details you would like to provide: ____

Please read the following and sign below:
I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

1. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
2. I understand that massage should not be performed under certain medical conditions and I affirm that I my answers pertaining to any medical condition(s) and history have been answered truthfully.

Client Signature____Date__________________