MASSAGE THERAPY HEALTH INTAKE QUESTIONNAIRE

Name: _____ Date of Birth: _____

Address: _____

Phone: (Day) _____ (Evening)_____ (Cell) _____ (Email) _____

Occupation: _____ Employer: _____

Physician: _____ Referred By: _____

Check the following conditions that apply to you, past and present. Please add your comment to clarify condition.

Muscular - Skeletal

___ Headaches
___ Joint Stiffness / swelling
___ Arthritis
___ Spasms / cramps
___ Broken / fractured bones
___ Strains and sprains
___ Back, hip pain
___ Shoulder, neck, arm, hand
___ Leg, foot pain
___ Chest, ribs , abdominal pain
___ Problems walking
___ Jaw pain / TMJ
___ Tendonitis
___ Bursitis
___ Arthritis
___ Osteoporosis
___ Scoliosis
___ Bone or Joint Disease
___ Fibromyalgia
___ Other _____

Circulatory and Respiratory

___ Dizziness/light-headedness
___ Shortness of breath
___ Fainting
___ Cold Feet or hands
___ Edema
___ Swollen ankles
___ Pressure sores
___ Varicose veins
___ Blood clots
___ Stroke
___ Heart condition
___ Cerebral Palsy
___ Sinus problems
___ Asthma
___ High Blood Pressure
___ Low Blood Pressure
___ Angina
___ Pacemaker
___ Other _____

Medical Conditions

___ Numbness/tingling
___ Fatigue
___ Chronic pain
___ Sleep disorders
___ Paralysis
___ Spinal cord injury
___ Epilepsy
___ Chronic Fatigue Syndrome
___ Multiple Sclerosis
___ Muscular Dystrophy
___ Parkinson's Disease
___ Cancer ____current ___ remission
___ Diabetes
___ Kidney Disease
___ Thyroid Problems
___ Depression ___ Anxiety
___ Drug use _____
___ Alcohol use _____
___ Nicotine use _____
___ Hearing Impairment ___ Hearing Aide
___ Visual Impairment ___ Contacts
___ Dentures/ removable bridgework
___ Prosthesis
___ Infectious Disease _____
___ Other _____

Skin

___ Rashes
___ Allergies
___ Athlete's Foot
___ Warts ___ Moles
___ Acne
___ Dermatitis
___ Eczema
___ Hives
___ Herpes / Shingles
___ Cosmetic Surgery
___ Other _____

Digestive

___ Nervous stomach
___ Indigestion
___ Constipation
___ Diarrhea
___ Diverticulitis
___ Irritable Bowl Syndrome
___ Urinary / bladder problems
___ Crone's Disease
___ Adaptive aids
___ Other _____

Reproductive

___ Pregnancy: ___ Current ___Previous
___ PMS ___ IUD
___ Menopause
___ Pelvic Inflammatory disease
___ Endometriosis
___ Other _____

Surgeries: _____

_____

Please list any additional comment regarding your health and well being: ex. stress, repetitive movements, sport or hobby activities

_____

_____

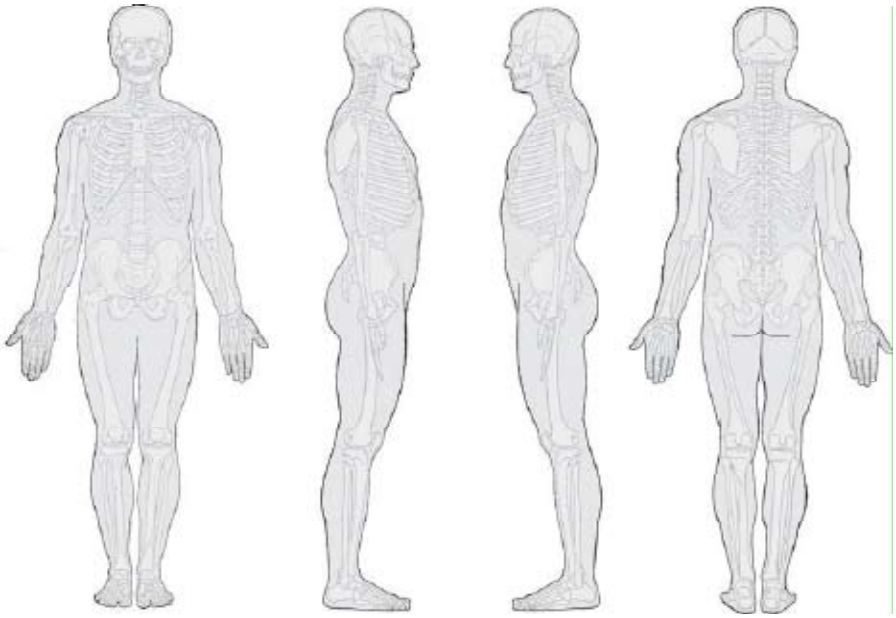
CURRENT MEDICATIONS

Name of Medication	Purpose	Name of Medication	Purpose

Current medical supervision: *ex. doctor, chiropractor, therapist* _____

_____ *previous body work :* _____

Please mark your area(s) of discomfort, tension and/or pain on the figure below



Pain Assessment : Bodily Discomfort

_____

_____

_____

_____

0 = No Pain ----------10 = extreme pain

GOALS FOR MASSAGE THERAPY

___ Relaxation / stress relief
___ Relief of pain / tension
___ Injury rehabilitation
___ General health maintenance
___ Improvement movement/ flexibility
___ Increase body awareness
___ Other: _____

WHAT TYPE OF PRESSURE DO YOU PREFER: ___ Light ___ Firm/medium ___ Deep

Any other comments/ requests you would like to add with regards to receiving your massage / bodywork treatment:

_____

_____

INFORMED CONSENT FOR MASSAGE THERAPY SESSION

I, _____(print your name) understand that the massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease. I affirm that I have stated all my known medical conditions and answered all questions honestly and complete to the best of my knowledge. I agree to keep the therapist updated as to any changes in my medical profile and understand there is no liability on the therapist's part.

If I experience any pain or discomfort during the session, I will immediately communicate it to the therapist so the treatment can be adjusted to my comfort level or stopped. If I have any questions about the therapy, I am free to ask at any time. I understand and agree that I am receiving massage therapy at my own risk.

It is necessary for the therapist to touch and observe my body in order to conduct this process. I am aware that massage work is performed directly on the skin with the use of lubricants and that all areas of my body not being massaged will remain draped. I give the therapist full permission to work on my body in such a way.

24 Hour Cancellation Notice or Change

Client Signature: _____ Date: _____ Any returned checks incur a fee of $35.00.