Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

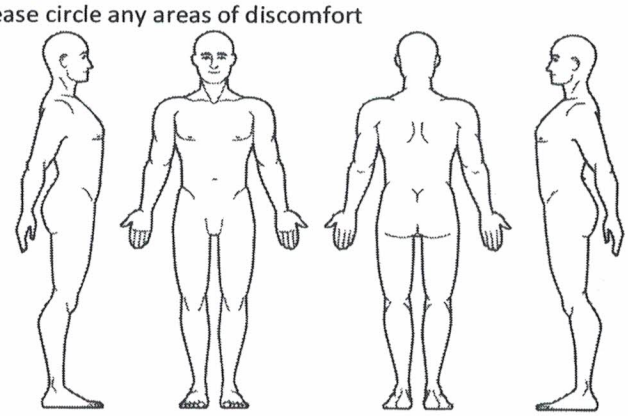
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

Client Name _____ **Date** _____

Therapist Name _____ **Duration Of Treatment** _____

SUBJECTIVE

Intensity of pain: *(circle one)*

1 2 3 4 5 6 7 8 9 10

Sensation of pain:

- ○ Dull
- ○ Sharp
- ○ Tender
- ○ Itching
- ○ Cramping
- ○ Throbbing
- ○ Tingling
- ○ Stiff
- ○ Other _____
- ○ Cold
- ○ Burning
- ○ Aching
- ○ Sensitive
- ○ Radiating
- ○ Shooting
- ○ Pressure

Time pattern of pain

- ○ Constant (pain does not change)
- ○ Intermittent (intensity doesn't change but comes & goes)
- ○ Variable (intensity changes throughout the day)

When did the pain start:

_____

Was there a specific incident that cause this pain?

- ○ Motor vehicle accident
- ○ Slept funny
- ○ Sports/exercise
- ○ Other _____
- ○ Fall
- ○ Work related

Pain/discomfort is brought on or made worse by...

_____

_____

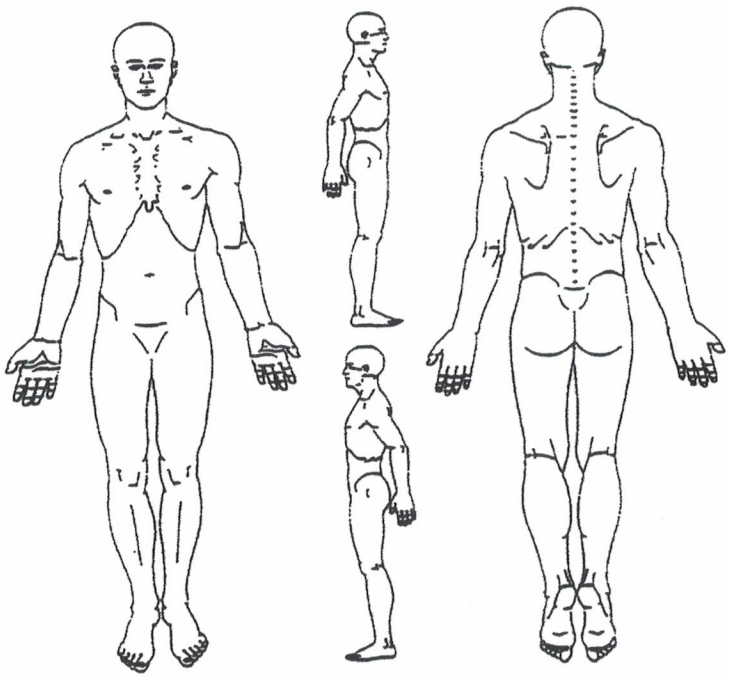
Pain/discomfort feels better with...

_____

_____

Primary area of pain:

- ✘ Adhesion
- ↻ Rotation
- ○ Pain
- • Tender Point
- ≡ Hypertonicity
- ≈ Spasm
- ☼ Inflammation
- ৭ Trigger point
- / Elevation



Does this pain prevent you from participating in...

- ○ Work
- ○ Sports/exercise
- ○ Other _____
- ○ Leisure activities
- ○ Sleep

Have you seen other practitioners about this issue?

- ○ Massage therapist
- ○ Chiropractor
- ○ Other _____
- ○ Physical therapist
- ○ Physician