Massage Intake Form

In order to provide you with the best possible massage, please complete this form in its entirety. All information is strictly CONFIDENTIAL.

Client Name:____________________________ Date:__/__/__
Address:____
City:____________________________State:____________ Zip Code ______________
Email:____
Phone (Day): (____)________________ Phone (Evening): (____)________________
Date of Birth: __/__/____Age:____
Occupation:_____________________________
Referred By:____________________________
Do you wear contacts? Yes__ No__ Dentures? Yes__ No__
Please list your primary health care professionals and phone numbers:
(MD, Chiropractor, Osteopath, Nurse Practitioner, Naturpath, etc)
____
____
____
Are you involved in any other therapies at this time? If so, what and how often?
____
____
Are you currently taking medications? For what? Please list:
____
____
Are you currently experiencing bodily tension or tightness?____If so, where?____________________________
____
How often do you, on a scale of 1-5 (1 Never, 3 Occasionally, 5 Frequently)
Smoke:______ Drink Alcohol:______ Consume Caffeine:______ Consume Refined Sugar:______
Do you have persistent pain?Yes__No__ Location?____

Determine degree of pain between 1 and 10 (10 being most painful) _____________________________
When did pain or tension start?____
Do you associate this condition with a specific activity (work, exercise, etc)?_______________________

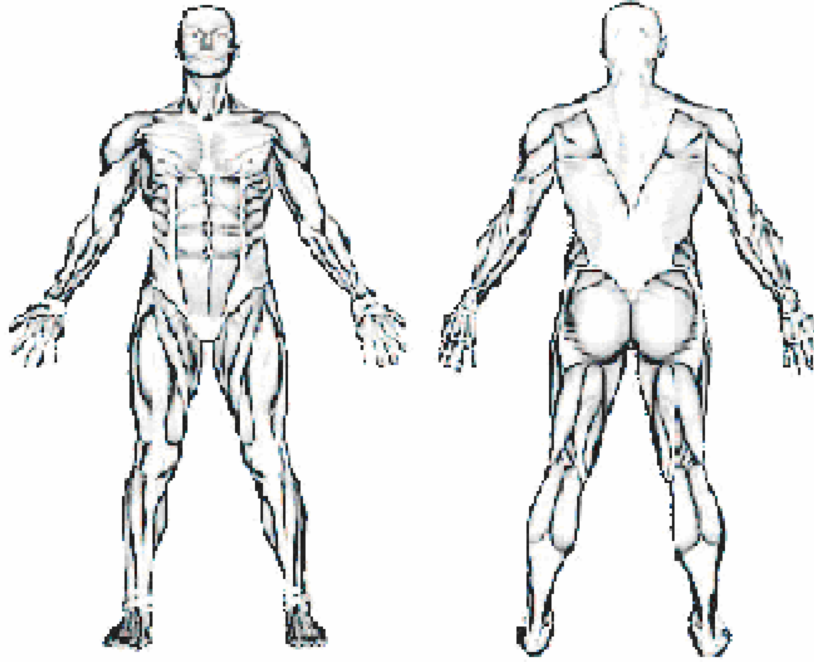
If you now have or have had a history of the following, please circle:

High Blood Pressure	**Severe Lacerations**	**Arthritis**
Hematomas	**Spastic Paralysis**	**Insomnia**
Heart Problems	**Fractures**	**Headaches**
Phlebitis	**Whiplash**	**Stiff Neck**
Cancer	**Constipation**	**Skin Diseases**
Herpes	**Diverticulitis**	**AIDS**
Varicose Veins	**Candida**	**Contagious Diseases**

Other__________________
Are you Pregnant? Yes ___ No ___If so, how many months?________
Please list any previous injuries, such as broken bones, severe sprains, sprains, whiplash, traumas, etc.
Provide date(s) of injuries.____
____
Briefly describe any surgical operations you have had. Provide date(s).____________________________
____
Do you feel as though you “hold” stress or tension in any part of your body? ___Yes ___No
If “yes”, is it occasional ______ or frequent______
Do you experience any of the following:
____Chronic Headaches
____Chronic Backaches
____Bruxism (clenching, grinding of teeth)
____Tightness in the jaw (especially upon waking)

(next page please)

On the diagrams below, please circle those areas that best correspond to the places where you feel you hold stress and/or tension areas where you may be currently experiencing discomfort or pain.



What type(s) of exercise do you do? How often? ____
____
Have you received massage therapy before? Yes____ No_____ With Whom?__________________________

Is there any other information you feel would be helpful to share with me at this time?

I understand that the services rendered are not a substitute for medical care and that any information provided is for educational purposes only and not diagnostically prescriptive in nature. I release Schone Services and Maximized Health of any responsibility if any injuries occur. I agree to actively participate as much as possible in my own healing and growth.

Client Signature:____Date:_____________