

# Health and Wholeness: Massage Intake Form

## Patient Information

Name \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female  
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_ Occupation \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_ Referred by: \_\_\_\_\_  
In case of emergency: \_\_\_\_\_ Phone \_\_\_\_\_  
Physician: \_\_\_\_\_ Phone \_\_\_\_\_

## Massage Information

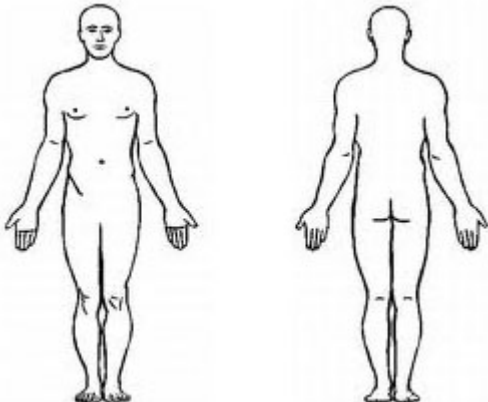
**Please take a moment to carefully answer the following questions. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.**

Have you had a professional massage before?  Yes  No  
If yes, how often do you receive massages? \_\_\_\_\_  
If yes, do you have a style or pressure preference?  Yes  No  
*Specify:*  light pressure  medium pressure  
 deep pressure  trigger point therapy  energy work  
 other \_\_\_\_\_

What type of massage are you seeking today?  
 Relaxation  Deep tissue/Therapeutic  Pregnancy  
 Senior  Integrated Bodywork  
 other \_\_\_\_\_

Are you sensitive to fragrances or perfumes?  Yes  No  
Do you have sensitive skin?  Yes  No  
Do you exercise regularly?  Yes  No  
What are you common areas of pain or tension?  
\_\_\_\_\_  
\_\_\_\_\_

Circle any specific areas you would like the massage therapist to concentrate on during the session:



## Medical History

Do you suffer from chronic or persistent pain/discomfort?  
 Yes  No If so, for how long? \_\_\_\_\_  
Do you know what causes/caused it or when the symptoms seem to get worse or better? \_\_\_\_\_  
Do you see a chiropractor?  Yes  No  
If so, how often? \_\_\_\_\_  
Are you currently under medical care?  Yes  No  
Are you currently taking any prescription medication? If so, for what? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate any condition that you have had or currently have:

<input type="checkbox"/> Headaches / Migraines	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Allergies / Sensitivity	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Arthritis / Tendonitis	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Cancer / Tumors	<input type="checkbox"/> Neck / Back injuries
<input type="checkbox"/> TMJ problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Abnormal skin condition	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Heart / Circulation problems	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Joint replacement / Surgery	<input type="checkbox"/> Numbness
<input type="checkbox"/> High/Low blood pressure	<input type="checkbox"/> Sprains, Strains
<input type="checkbox"/> Major accident	<input type="checkbox"/> Recent injuries
<input type="checkbox"/> Lack of or reduced feeling / Sensation	_____

Explain any condition you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(over)

## Patient Consent for Treatment

Please read and sign below.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Practitioner Signature \_\_\_\_\_

Date \_\_\_\_\_