A Matter of Muscles

THERAPEUTIC MASSAGE

Find the balance, relieve the discomfort

Client Intake Form

Name ______________________________ Date of Birth ______________

Address ____________________ City __________ State _____ Zip ________

Primary Phone # __________________ Secondary Phone # __________________

Email Address ________________________ Referred by ________________

Emergency Contact Information

Name ________________ Relationship ___________ Phone # ____________

How would you rate your general health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Have you had a professional massage before?
◯ Yes (Date of last treatment) ____________
◯ No

List current medications & the conditions they are treating

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List any allergies or hypersensitivities

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List any major accidents or surgeries (including dates)

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Reason for today's visit

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HEAD/ NECK

- ○ Headaches/ migraines
- ○ Vertigo/ dizziness
- ○ Ringing in ears
- ○ Hearing loss
- ○ Vision problems
- ○ Vision loss

RESPIRATORY

- ○ Asthma
- ○ Shortness of breath
- ○ Chronic cough
- ○ Bronchitis
- ○ Emphysema
- ○ Sinusitis
- ○ Frequent colds
- ○ Smoker
- ○ Family history of respiratory difficulties

NERVOUS SYSTEM

- ○ Sensory loss/ change
- ○ Numbness/ tingling
- ○ Sciatica
- ○ Epilepsy
- ○ Seizures
- ○ Multiple Sclerosis

MUSCULOSKELETAL SYSTEM

- ○ Arthritis
- ○ Family history of arthritis
- ○ Osteoporosis
- ○ Tendonitis
- ○ Bursitis
- ○ Jaw pain (TMJ)
- ○ Pins/ Plates/ Wires/ Artificial joint

REPRODUCTIVE

- ○ Pregnant
- ○ Given birth
- ○ Gynecological problems

CARDIOVASCULAR

- ○ High blood pressure
- ○ Low blood pressure
- ○ Heart attack
- ○ Stroke
- ○ Heart disease
- ○ Poor circulation
- ○ Hemophilia
- ○ Pacemaker
- ○ Phlebitis/ varicose veins
- ○ Chronic congestive heart failure
- ○ Family history of cardiovascular problems

SKIN & INFECTIONS

- ○ Hepatitis
- ○ HIV/ AIDS
- ○ Herpes
- ○ Tuberculosis
- ○ Lyme disease
- ○ Infectious skin conditions

OTHER CONDITIONS

- ○ Cancer
- ○ Diabetes
- ○ Fibromyalgia
- ○ Digestive conditions
- ○ Depression
- ○ Chronic fatigue syndrome
- ○ Anxiety
- ○ Psychiatric disorder
- ○ Unexplained weight loss
- ○ Other conditions ______________________________

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It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care provders involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Client Name ____

Client Signature ____ Date ______________________________