INTEGRATIVE BODYWORK & MASSAGE

Massage Therapy Intake Form

CONFIDENTIAL INFORMATION

Today's Date ______________________

Name ______________________ Date of Birth ______________________

Address ______________________

City ______________ State ______________ Zip ______________

Phone (home) ______________ (work/cell) ______________ email ______________

Occupation ______________ Height ______________ Weight ______________

Emergency contact name & number ______________________

Referred by: ______________________

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below ______________________

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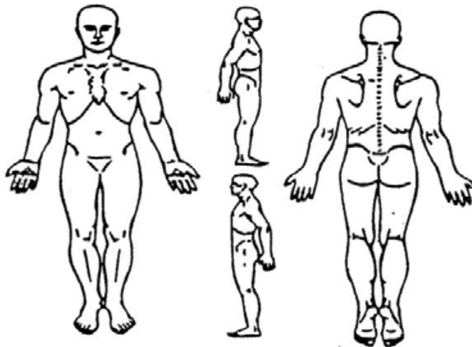

Describe any chronic pain/tension______________________

Are you currently under the care of a physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? ______________________

Is this massage/bodywork medically necessary (medical condition, injury, surgery)? Yes No

Do you have a physician referral/prescription? Yes No

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking:______________________

Are you currently pregnant? ______________How many weeks______________

Have you ever had cancer? If so, was it past or present? What type? ______________

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Please check any of the following that apply to you in the past or present:

Condition/Complaint	Yes	No	Condition/Complaint	Yes	No
Headaches Type:			Pins and Needles in arms, legs, Hands or feet		
Asthma			Neurological problems		
Cold Hands/feet			Spinal Problems		
Swollen ankles			Herniated/Bulging Discs		
Sinus Conditions			Osteoarthritis		
Frequent Colds			Arthritis		
Allergies (specify above)			Anxiety		
Loss of smell/taste			Depression/Panic		
Skin Conditions			Sleep Disturbance		
Painful/Swollen Joints			Loss of Memory		
Auto-immune disorder			Whiplash		
Cancer			Bruise Easily		
Varicose Veins			Constipation/Diarrhea		
Blood Clots/DVT			Injuries		
Heart Problems			Recent Surgeries		
Pacemaker			Hemorrhoids		
High/Low BP			Artificial/Missing limbs		
Diabetes			Muscular Tension		
Epilepsy or Seizures			Sciatica		
Fainting Spells			Ticklish		

*Further explanation of any condition or other information:*___________________________________

What specific areas would you like for to focus on? ____________________________

Are there any areas you do **NOT** like massaged? (i.e. feet, stomach, head, face)?____________

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

☯*Need to move or change positions* ☯*Sighing, yawning, change in breath* ☯*Stomach gurgling*
☯*Emotional feelings and/or expressions* ☯*Movement of intestinal gas*
☯*Energy shifts* ☯*Falling asleep* ☯ *Memories*

- I understand the treatment here is not a replacement for medical care.
- As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice)
- I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- I understand that therapist/practitioner shall not engage in breast massage of female clients without the written consent of the client.
- I understand that draping will be used during the session, unless otherwise agreed to by both the client and the therapist/practitioner.
- I understand that if uncomfortable for any reason, the client or the therapist/practitioner may ask to cease the massage and end the session.

Client signature____Date_________________________

Therapist/practitioner ____Date_________________________

Integrative Bodywork & Massage

We know that it's your first time in our clinic and we want to thank you for being here!

We'd like for you to take a minute to answer some questions so we can better customize your experience with us!

Have you ever had a professional massage before? Yes No

What type of massage do you prefer? ____

What type of pressure do you prefer? Light Medium/Firm Deep

When was your last massage? ____

What do you hope to accomplish with this massage? (i.e. relaxation, decrease pain, increase flexibility, etc.)

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How often do you get massaged? Once a week month never

How often do you see yourself getting massaged? ____

Who referred you? ____

Are you aware of the health benefits of regular massage? Yes No