

MASSAGE INTAKE FORM

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ D.O.B. _____
Age: _____ Gender: _____ Social Security Number: _____
Driver's License #: _____ Marital Status: _____

Spousal Information:

Name: _____ Employer: _____ Employer's
Address: _____ City: _____ State: _____
Cell Phone: _____ Work Phone: _____

Employment Information:

Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____
Work Phone: _____

Emergency Contact Information

Name: _____ Phone: _____

Who can we thank for referring you to the office? _____

List All Accidents, Injuries, and Surgeries in last 5 years: _____

List all current Medications and purpose (include over the counter): _____

List all allergy information including skin sensitivity or concerns: _____

Describe Current Symptoms: _____

Do you wear contacts: _____ Are You Pregnant: _____

Are you currently experiencing any of the following? Fever, infection, inflammation, Flu/Cold: Please Circle:

How do you rate your overall health: _____ Do you live an active lifestyle: _____

Have you had massage care before: _____ Please describe your experience: _____

Have You Ever Experienced Any Of The Following Conditions? Please Circle:

Headaches Tightness in the throat Thyroid problems Loss of memory Fatigue Seizures Skin Disorders Pain or numbness Breast tenderness Varicose veins Neck problems shoulder problems chest pain Heart attack High or Low BP Nervousness Whiplash Painful menstruation(cramps) Infections Sinus problems Asthma Shortness of breath TB Anemia Liver trouble PMS Fractures Constipation Gallbladder problems Kidney problems Diabetes Swollen or painful joints Arthritis Pain in the legs Pregnancy Cancer HIV All Allergy Information (other):

Please explain: _____

PLEASE READ AND SIGN THE FOLLOWING:

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I also understand that I am responsible if third party payment is not made. I agree to give 24 hours notice of cancellation of appointment. If less than 24 hour notice I will be charged \$25.00. In cases of emergency exceptions are made.

Patient Signature: _____ Date: _____

