Name: _____DOB: _____
Address: _____
City: _____ State: _____
Zip: _____
Home Phone: _____Cell Phone: _____
Email Address: _____
Referred by: _____ Occupation: _____
In case of emergency: _____ Phone: _____

Massage Treatment Intake

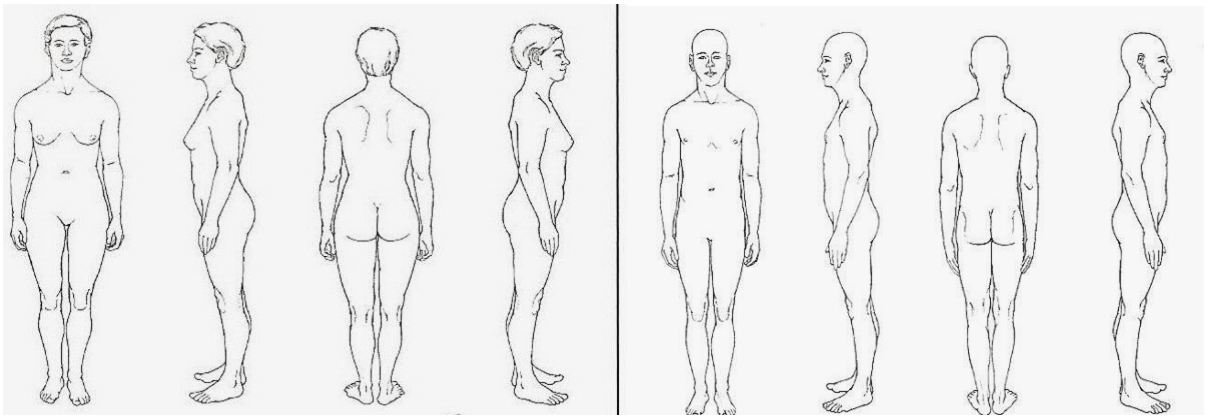
Have you had a professional massage before? _____ How recently? _____

Circle the primary purpose of today's visit?
Pain relief Relaxation Therapeutic PIP Other_____
Any injuries in the past two years? _____
If yes where were the injuries located and when? _____
Other medical condition? If yes please list them: _____
Are you taking Blood Thinners or any other medications? If yes please list them:
_____

Please circle any symptoms/conditions that are current or have been present in the last six months: **Stress Headaches Pregnancy Arthritis High Blood Pressure Varicose Veins Contagious Diseases Allergies Back Pain Heart Disease Head Cold Breathlessness Abdominal Pain Digestion Issues**
Other_____

Please mark any areas of tension below

FEMALE ***MALE***



Circle one: 0- No Pain 1-2-Mild 3-4-Nagging 5-6-Distressing 7-8-Horrible 9-10-Worst Possible

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service. I have stated all known medical conditions and will update the massage practitioner in writing of any changes in my health status if necessary.

Signed: _____ Date: _____
(Client or responsible party)