THERAPEUTIC MASSAGE INTAKE FORM

Patient Name: ______________________ Date of Birth: ___________ Date: ___________ Patient No: _______

Occupation: _______________ Gender: ___ Have you ever received a professional massage? _____________

Have you ever received a professional massage? ____ List known allergies or sensitivities: _______________

Check (√) any or all that apply to your present health:

- □ Headaches
- □ Chronic pain
- □ Varicose veins
- □ Blood clots
- □ Vision problems
- □ Muscle/Joint pain
- □ Jaw pain/teeth grinding
- □ Sprains/strains
- □ Scoliosis
- □ Cancer/tumors
- □ Arthritis
- □ Infectious disease
- □ Tendonitis
- □ Prostate problems
- □ Endometriosis
- □ Fatigue
- □ Skin problems
- □ Sinus problems
- □ Diabetes
- □ Numbness/tingling
- □ Depression
- □ Painful menses
- □ Sleep difficulties
- □ High/low blood pressure

Check (√) the appropriate areas of concern:

- □ Head & neck
- □ Upper back
- □ Mid-back
- □ Low back
- □ Hips & Thighs
- □ Knees & Legs
- □ Feet & Ankles
- □ Shoulders & arms
- □ Hands & Wrists
- □ Other areas (Please explain)

Remarks: ____

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By signing this consent form, I understand a massage therapist CANNOT diagnose illness, disease or any other medical, physical or emotional disorder, nor perform spinal manipulation. It is my responsibility to consult a qualified physician for medical advice and/or treatment. I understand that massage therapy is a health-aide only.

Patient Signature: ____ Date: ________________________________