Massage Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name	Date of birth				
Address					
State City	Home Phone				
Work Phone	Occupation				
Have you ever received massage therapy?	Yes No				
Type of massage experienced (swedish, shiatsu, deep tissue, etc.)					
Are you currently taking any medications?	Yes No				
If yes, please list name and reason for medications					
Are you currently seeing a healthcare professional? Yes No If yes, please list names and reason/treatment					
diabetesblood clotsbroken/dislocated bonesbruise easilycancerchronic painconstipation/diarrheaauto-immune condition*hepatitis (A, B, C, other)skin conditionsstrokesurgeryTMJ disorder (*AIDS, fibromyalgia, chronic fatigue, lupus, etc.	next to the condition. depression, panic disorder, other psych conditiondiverticulitisheadachesheart conditionsback problemshigh blood pressureinsomniamuscle strain/sprainpregnancyscoliosisseizureswhiplashchemical dependency (alcohol, drugs))				
If any of the above needs to be detailed or if there is anything else to share,					
please do so:					

Do you have any of	the following to	day:								
skin ra	ash co	old/flu	_ open cuts	severe pain						
anything contagious injuries/bruises Do you have any allergies to: medications foods (nuts, etc.)										
						environmental allergens (dust, pollen, fragrances) reactions to skin care products				
•		J								
Are you wearing: _	contact le	enses h	nearing aid h	airpiece						
Please indicate with			_	•						
What are your goals	/expectations fo	or this therapy	session?							
The following s	ometimes occu	rs during massa	ige. They are norma	al responses to						

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

need to move or change position * sighing, yawning, change in breathing stomach gurgling * emotional feelings and/or expression movement of intestinal gas * energy shifts * falling asleep * memories

Please read the following information and sign below:

- 1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
- 2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
- 3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature:	Date