



Therapeutic & Wellness Massage

MASSAGE THERAPY HEALTH INTAKE

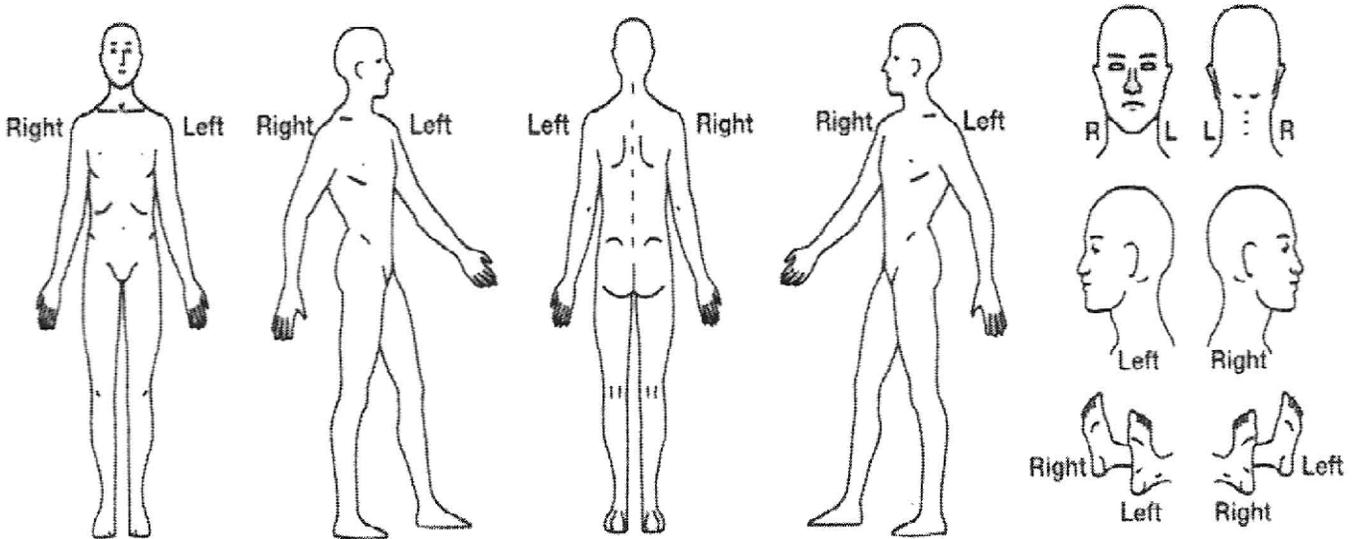
PERSONAL INFORMATION

Name: _____ Date of Birth: ____/____/____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (home): _____ Phone (cell): _____
 Email: _____ Occupation: _____
 Are you planning on purchasing a Treatment Package? Y N
 Are you currently in physical therapy? Y N
 What is your condition? _____
 Is this your first massage? Y N
 In case of an emergency, contact: _____ Phone: _____

PRECAUTIONS

Are you pregnant? Y N If yes, how far along? _____
 What is the major complaint or goal/condition you are trying to improve/achieve from your therapy session: _____
 Are you allergic to latex or any oils/lotions? Y N If yes, please list: _____

Please mark or circle the areas needing attention during your massage session today on the diagram:



MEDICAL HISTORY (Please indicate with an 'X')

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Headaches/Head Injuries | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Allergies/Skin Allergies | <input type="checkbox"/> Hearing Aide | <input type="checkbox"/> Sciatica/Leg Pain |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Heart Condition/Disease | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems/Sinusitis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hernia/Repair | <input type="checkbox"/> Skin Infection/Disease |
| <input type="checkbox"/> Bone or Joint Disease/Arthritis | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Spasms/Cramps |
| <input type="checkbox"/> Breathing Difficulties/Asthma | <input type="checkbox"/> Herpes/Shingles | <input type="checkbox"/> Spinal Injury/Conditions |
| <input type="checkbox"/> Broken/Fractured Bones | <input type="checkbox"/> High Blood Pressure/Hypertension | (Scoliosis) |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Jaw Pain/TMJ | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Dental Appliance | <input type="checkbox"/> Low Blood Pressure/Hypotension | <input type="checkbox"/> Tendonitis/Bursitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lupus/MS | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dizziness/Vertigo/Fainting | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Eye Glasses/Contact Lenses | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Fibromyalgia/Myofascial Syndrome | <input type="checkbox"/> Numbness/Tingling | _____ |
| <input type="checkbox"/> Gas/Bloating/Constipation/Irritable Bowel Syndrome | <input type="checkbox"/> Osteoporosis/Osteopenia | _____ |
| | <input type="checkbox"/> Pacemaker | |
| | <input type="checkbox"/> Poor Circulation | |

Medications currently taking: _____

Please list and date any surgeries, injuries, or significant past medical history: _____

RELEASE

*I, the undersigned, understand that Massage Therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. Information exchanged during massage sessions is educational in nature and is to be used at my own discretion. I understand that Massage Therapy is for the purpose of general health maintenance, stress reduction, relief from muscular tension, adjunct to optimal athletic performance, general relaxation, and improvement of circulation. This massage treatment may include muscular tension release, myofascial release, CranioSacral Therapy, trigger point therapy, joint mobilization, stretching and manual therapy. I agree to communicate with my massage therapist if, at any time, I feel that my well-being and/or comfort is being compromised. I also understand that the Massage Therapist does not diagnose any illness, disease, or any other physical or mental disorders; does not prescribe medical treatments or pharmaceuticals; nor does he/she perform any spinal adjustments. It has been made clear to me that professional Massage Therapy is not a substitute for medical treatment and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on changes in my physical health. With this in mind, I agree that the Massage Therapist cannot be held liable for any problems that may arise as a result of my sessions. I agree that payment is due prior to the massage session. **If you are unable to keep the appointment, please notify us 24 hours prior to your scheduled appointment. Appointments that have not been canceled will be billed directly to the client.** Thank you for your professional consideration, courtesy, and promptness.*

Patient Signature _____ Date _____

Parent/Guardian Signature (if minor) _____ Date _____

YOUR PRIVACY

Your treatment sessions are documented and *as noted in our Notice of Privacy Practice*, your privacy is a chief concern of your massage therapist.

*Insurance reimbursement is dependent upon your personal health insurance company. It is **your responsibility** to keep copies of and submit your receipts to your insurance company for **possible** reimbursement. Therapeutic and Wellness Massage, LLC is **not** responsible for any insurance billing.*