KEEP THE BALANCE

MASSAGE THERAPY INTAKE FORM

Name: _____ *Date:* _____

Address: _____ *Date of Birth:* _____

City: _____ *State:* _____ *Zip:* _____

Home #: _____ *Cell#* _____

Email: _____

Occupation: _____ *Referred By:* _____

Emergency Contact: _____ *Phone #:* _____

Is this your first professional massage? _____ *Do you wear Contact lenses?* _____

PLEASE COMMENT ON ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH

Are you receiving medical or chiropractic treatment? _____

If yes, please explain: _____

_____

Physician: _____ *Phone #:* _____

Surgeries: _____

Injuries: _____

Chronic or major illness: _____

Current medication(s): _____

Do you have chronic pain? _____ *Where?* _____

Stress factors in your life: _____

Where in your body do you feel the effects of stress: _____

What do you do for relaxation/exercise? _____

CONFIDENTIAL MEDICAL HISTORY AND CONTRAINDICATIONS

Please circle any of the following conditions you are currently experiencing:

Pregnancy *Flu or Cold* *Infection*

Inflammation *Fever* *Contagious Disease*

OVER

Skin Conditions:

Cancer or undiagnosed growths

Compromised immune system: *Allergies* *Anemia* *HIV* *AIDS*

Contagious skin diseases: *Rash* *Sores* *Infection*

Skin sensitivity/irritability: *Bruises* *Scars* *Edema* *Lack of sensation*

Explain: _____

Cardiovascular Conditions:

General: *Diabetes* *Constipation (chronic or mild)*

Circulatory: *High blood pressure* *Varicose veins*

History of blood clots *Phlebitis*

Cardiac: *Heart disease* *Pacemaker*

Respiratory: *Emphysema* *Asthma*

Bronchitis *Shortness of breath*

Explain: _____

Orthopedic Conditions:

Osteoporosis *Osteoarthritis* *Rheumatoid arthritis*

Musculoskeletal pain, stiffness, or stress

Any joint, neck, back injuries, or fractures

Explain: _____

Neurological Conditions:

Multiple sclerosis *Parkinson* *Cerebral palsy* *Head injury*

Epilepsy *Stroke* *Headaches* *Inner ear disturbances*

Emotional loss: *Death* *Disability* *Trauma* *Stress* *Depression*

Explain: _____

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 those services.

I also agree that massage therapy treatment are my personal financial responsibility and that I am to pay for those services at the time of treatment unless other written arrangement have been made and that I must change or cancel appointments with at least 24 hours notice or I will be charged the full price of my massage.

Signed: _____ *Date:* _____