

Welcome



Massage Intake Form

Personal Information:

Name _____ Phone (Cell) _____ (Home) _____
 Address _____ City/State/Zip _____
 DOB _____ Email _____ Occupation _____
 Emergency Contact _____ Relationship _____ Phone _____
 Sex: Male Female Other How did you hear about us? _____

Medical Information:

Are you taking any medication? Yes No If Yes, Please list name and use: _____
 Are you currently Pregnant? Yes No If yes, How far along? _____ Any High Risk factors? _____
 Do you suffer from Chronic Pain? Yes No If yes, Please explain _____
 What makes it better? _____
 What makes it worse? _____
 Have you had any Orthopedic Injuries? Yes No If yes, Please list _____

Please Indicate Any Of The Following That Apply To You:

Cancer Headaches/Migraines Arthritis Diabetes Joint Replacement(s) High/Low Blood Pressure
 Neuropathy Fibromyalgia Stroke Heart Attack Kidney Dysfunction Blood Clots Numbness
 Sprains/Strains Explain any conditions you have marked above: _____

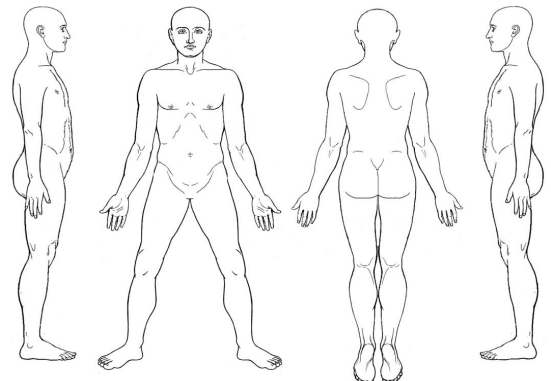
Massage Information:

Have you had a professional massage before? Yes No
 What pressure do you prefer? Light Medium Deep
 Do you have any allergies/sensitivities? Yes No
 Please Explain _____
 Reason for Visit _____
 Rate your pain from 1(least pain) to 10(severe pain) _____

Type of pain:

Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other
 How often do you have this pain? _____
 Does it interfere with your: Work Sleep Daily Routine Other _____
 Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

Please circle any discomfort:





Before your massage session begins, please read the following information to better prepare you for your treatment. The Medical Massage Clinic, consists of certified Massage Therapists trained in Medical Massage Therapy with excellent treatments for the injured patients.

The Medical Massage Clinic would like you to know you are very important to us and that we consider it a privilege to be able to provide you with the highest quality medical massage therapy services. Please take time to read through this information and medical questionnaire. For your comfort, during your massage session please feel free to give your massage therapist any feedback concerning your comfort level. You may ask for more or less pressure according to your sensitivity. Your comfort level is important and your feedback and comments are essential for helping break the pain cycle!

Please be respectful of other clients that are trying to relax. We ask that you DO NOT bring small children into the office. If you do and they are disruptive, we will have to end your session and charge you the full amount of your service.

I understand that this therapeutic therapy session is provided for the basic purpose of relaxation, stress reduction, and most important relief of pain, muscular tension and tightness. If I experience any undo pain or discomfort during the treatment, I will immediately inform the therapist, so the pressure may be adjusted to my best comfort level. I understand that the treatment may cause some undesirable side effects that may occur during or up to 36 hours after the treatment. Some of the effects may be the following:

Slight Headache

Nausea

Lightheadedness

Achy or Sore Muscles

Some interactions are due to an increase of metabolic toxin waste in the circulatory system. This waste may put an extra burden on the excretory system. If this waste and toxins are not flushed out of the system, it will be reabsorbed into the tissue of the muscle. The patient's experience may depend on the organs that are being overtaxed. The patient will seldom have a symptom that lasts for any length of time up to 36 hours. I understand that an increase in water intake and other healthful fluids will assist the process of elimination by supplying more fluids for the kidney, colon and lungs. I understand that no treatment performed by the Medical Massage Clinic should be construed as a substitute for a medical examination or diagnosis. I affirm that I have listed and stated all my known medical conditions, and I understand that there shall be no liability on the Medical Massage Clinic.

It is also understood that any illicit or sexually suggestive remarks or advances made by the patient will result in immediate termination of the treatment.

I agree to honor my therapist the respect of their time. If I need to cancel my appointment for any reason I will give a 24 hour notice. If I fail to do so I will be charged \$40.

Patient Signature _____ Date _____

