Massage Therapy Patient Intake Information

Name_____ Date_____

Address_____ City & State_____ Zip_____

Phone (Day)_____ (Evening)_____ Email_____

Date of Birth_____ Occupation_____

Insurance_____ Name of Insured_____ ID#_____

Referring Physician_____ Phone_____ Fax#_____

Physician's
Address_____

Date of Injury/Onset_____ Was it a result of an auto accident? (yes/no)

If yes: Insurance Company Name_____

Phone_____ Claim #_____

Emergency Contact_____ Relationship_____ Phone_____

Medications currently taking_____

Current Issues/concerns_____Previous Massage Experience_____

Within the last 3-days, have you experienced any of the following conditions: (yes/no)
☐Flu or Cold ☐Inflammation ☐Fever ☐Infection ☐Contagious Disease
Is there any chance of pregnancy? (yes/no) Weeks?_____Are you feeling well right now?(yes/no)
Please indicate if you have experienced any of these conditions:

☐AIDS/HIV	☐Diabetes	☐Heart Problems	☐Insomnia	☐Skin Disease/Rash
☐Allergies	☐Easy Bruising	☐Hematoma	☐Migraines	☐Stiff Neck
☐Arthritis	☐Epilepsy	☐Hepatitis	☐Osteoporosis	☐Surgery (any)
☐Back Pain	☐Fibromyalgia	☐Herpes	☐Phlebitis/Clots	☐Varicose Veins
☐Cancer	☐Fractures	☐High/Low BP	☐Postural Problems	☐Wear Contacts
☐Chronic Pain	☐Headaches	☐Injury (any)	☐Pressure sensitivity	☐Whiplash

Other important information (explain tension/pain areas)_____

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Please read the following information and sign where indicated.

Some specific conditions may not benefit from massage/bodywork and may be contra-indicated. The therapist in attendance has the right to refuse massage/bodywork in the event she thinks it may be more harmful than beneficial for the client. The attending therapist may refer you to your primary care physician if required, for she is not qualified to make diagnosis or prescribe treatment for medical conditions.

I understand that the therapist is also not qualified to perform spinal or skeletal adjustments and that massage/bodywork is primarily on the soft tissue and is for the express purpose of relaxation and stress relief. I also understand that at any time during the session that I have the privilege as well as the obligation to inform the therapist of any pain or excessive pressure that causes me discomfort.

I understand that no illicit or sexually suggestive remarks or advances will be tolerated and that the session will end immediately in the event of such actions. I affirm that the above information is true and accurate to the best of my knowledge.

Patient Signature_____Date_____

Therapist Signature_____Date_____