



MESSAGE CLIENT INTAKE FORM

Personal Information				
Last Name		First Name		Middle Initial
Date of Birth	Sex	Weight	Blood Type	
Address				
City		State	Zip Code	
e-mail		Phone Number		

Medical History	
Check all that apply:	
<input type="checkbox"/> osteoporosis <input type="checkbox"/> Joint stiffness/swelling <input type="checkbox"/> Spasms/cramps <input type="checkbox"/> Broken/Fractured bones <input type="checkbox"/> Strains/Sprains <input type="checkbox"/> back, hip pain <input type="checkbox"/> carpal tunnel syndrome <input type="checkbox"/> Shoulder, neck injury or pain <input type="checkbox"/> Leg, foot pain <input type="checkbox"/> Problems walking <input type="checkbox"/> Jaw pain/TMJ <input type="checkbox"/> Scoliosis <input type="checkbox"/> fibromyalgia <input type="checkbox"/> cold feet or hands	<input type="checkbox"/> Indigestion <input type="checkbox"/> Intestinal gas/bloating <input type="checkbox"/> Diarrhea <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcers <input type="checkbox"/> depression <input type="checkbox"/> headaches <input type="checkbox"/> numbness/tingling <input type="checkbox"/> paralysis <input type="checkbox"/> stroke <input type="checkbox"/> epilepsy <input type="checkbox"/> cancer <input type="checkbox"/> Allergies:
Do you currently have?	
<input type="checkbox"/> contagious skin condition <input type="checkbox"/> open sores or wounds <input type="checkbox"/> easy bruising / hemophilia <input type="checkbox"/> recent accident or injury <input type="checkbox"/> recent fracture <input type="checkbox"/> recent surgery <input type="checkbox"/> artificial joint <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> tuberculosis <input type="checkbox"/> hepatitis <input type="checkbox"/> current fever	<input type="checkbox"/> swollen glands <input type="checkbox"/> allergies/sensitivity <input type="checkbox"/> heart condition <input type="checkbox"/> high or low blood pressure <input type="checkbox"/> hearing aid <input type="checkbox"/> dentures <input type="checkbox"/> contact lenses <input type="checkbox"/> loss of appetite <input type="checkbox"/> sleeping disorder <input type="checkbox"/> orthotics (how old? _____) <input type="checkbox"/> pregnant
Are you currently taking pain medication, narcotics, NSAIDs, muscle relaxants or steroids?	How would you rate your state of health?
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR

Waiver
<p><i>I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.</i></p> <p>Signature: _____ Date: _____</p>

Personal Habits

How many days/week do you consume:

___ Alcohol ___ Tea ___ Aspirin
___ Coffee ___ Sugar ___ Hormones
___ Tobacco ___ Laxatives ___ Sedatives
___ Soda ___ Vitamins

Describe how you sleep:

- Back
 Side
 Stomach

Mattress Age: ___ Pillow Type: _____

Usual Bedtime: _____ Usual Wake Time: _____

Physical Issues

Circle the areas on which you would like the therapist to focus.



Further describe any issues from your medical history: