Massage Intake Form

Waters of Atlantis Massage

Client Information

Name _____ Date _____

Street _____ Day Phone ( ) _____

City _____ State _____ Zip _____ Eve Phone ( ) _____

Occupation _____ Date of Birth _____

Emergency Contact Name and Phone _____ ( ) _____

Referred By _____ Email _____

Massage History / Session Information

Have you ever received a professional massage? ☐ Yes ☐ No Date of last massage _____

What result do you want from your massage sessions? _____

List any exercise activities. Include frequency: _____

_____

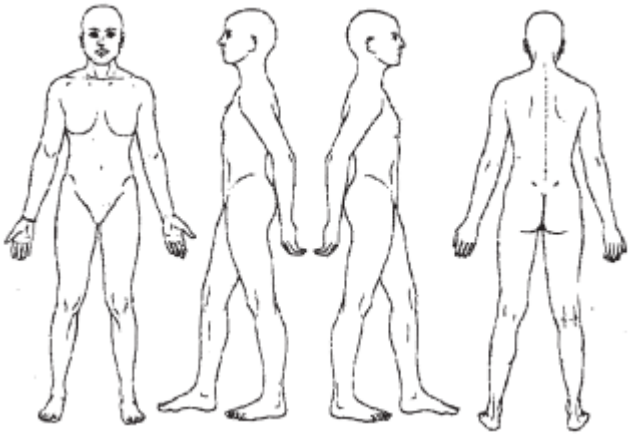
Are you currently under the care of a health care practitioner? ☐ Yes ☐ No

If yes, specify purpose: _____

List current medications and purpose: _____

_____

Where is your pain?



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Previous History (Include year & treatment received)

Surgeries:_____

_____

Accidents: _____

Health History

Musculoskeletal

- ❒ Bone or Joint Disease
- ❒ Tendonitis/Bursitis
- ❒ Broken/Fractured Bones
- ❒ Arthritis/Gout
- ❒ Jaw pain/TMD
- ❒ Lupus
- ❒ Sprains/Strains
- ❒ Low Back, Hip, Leg Pain
- ❒ Neck, Shoulder, Arm Pain
- ❒ Headaches, Head Injuries
- ❒ Spasms/Cramps
- ❒ **Other:**_____

Circulatory

- ❒ Heart Condition
- ❒ Varicose Veins/Phlebitis
- ❒ Blood Clots
- ❒ High/Low Blood Pressure
- ❒ Lymphedema
- ❒ Thrombus/Embolism
- ❒ **Other:**_____

Respiratory

- ❒ Breathing Difficulty/Asthma
- ❒ Emphysema
- ❒ Allergies; Specify:_____
- ❒ Sinus Problems
- ❒ **Other:**_____

Nervous

- ❒ Herpes/Shingles
- ❒ Numbness/Tingling
- ❒ Pinched Nerve
- ❒ **Other:**_____

Reproductive

- ❒ Pregnant; Trimester: _____
- ❒ Ovarian/Menstrual Problems
- ❒ Prostate
- ❒ PMS
- ❒ **Other:**_____

Skin

- ❒ Allergies; Specify:_____
- ❒ Rashes
- ❒ Athletes Foot
- ❒ Herpes/Cold Sores
- ❒ Warts
- ❒ **Other:**_____

Digestive

- ❒ Constipation
- ❒ Gas/Bloating
- ❒ Diverticulitis
- ❒ Irritable Bowel Syndrome
- ❒ Ulcers
- ❒ **Other:**_____

Other

- ❒ Cancer/Tumors
- ❒ Diabetes
- ❒ Chronic Fatigue
- ❒ Chronic Pain
- ❒ Eating Disorders
- ❒ Sleep Disorders
- ❒ Bladder/Kidney ailment
- ❒ Drug/Alcohol Addiction
- ❒ Caffeine/Tobacco Addiction
- ❒ Migraines/Headaches
- ❒ Anxiety/Stress Syndrome
- ❒ Depression
- ❒ Contact Lenses

Consent & Contract for Care:

It is my choice to receive massage therapy and I give my consent to receive treatment. I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.
I understand that a massage therapist cannot diagnose illness, disease, or any other medical, mental, or emotional disorder. Nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I realize that the treatment is being given for the well being of my body, mind and spirit. This includes stress reduction, relief from muscular tension, spasm or pain, also for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my wellbeing is compromised. I acknowledge that massage is not a substitute for medical examination or diagnosis; I am responsible for consulting a qualified physician for any physical ailments that I have.
I understand that massage therapy is a therapeutic health aide and is non-sexual.

PATIENT SIGNATURE:_____ **DATE:**_____

THERAPIST SIGNATURE:_____ **DATE:**_____