

MASSAGE THERAPY - INTAKE

Name: _____ DOB: _____

Occupation: _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Have you had a professional massage before? () YES () NO

If yes, how often do you receive massage therapy? _____

If yes, what type of massage do you prefer? () Relaxation () Therapeutic () Deep Tissue

2. During your massage do you like? () Talking () Music () Heat

3. Do you have any difficulty lying on your front, back, or side? () YES () NO

If yes, please explain _____

4. Do you have any allergies/skin sensitivities to oils or lotions? () YES () NO

If yes, please explain _____

5. Do you experience stress in your work, family, or other aspect of your life? _____

6. On the scale of 1 - 10 identify the intensity of your pain/discomfort.

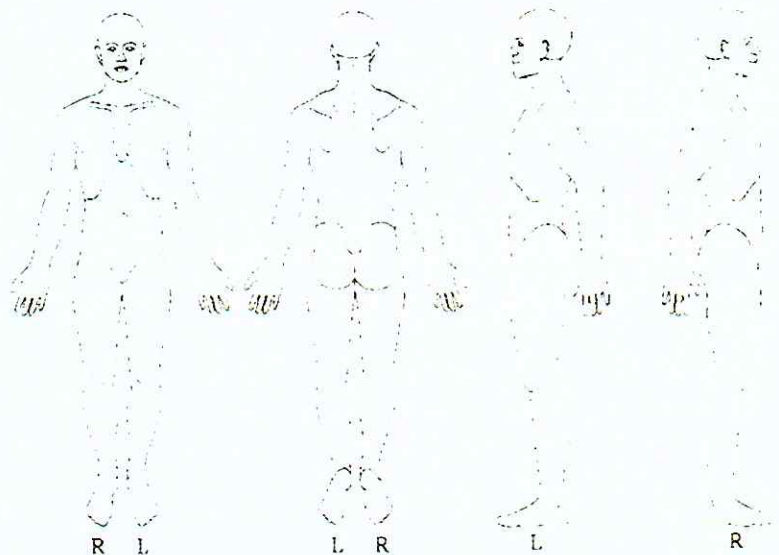
1 2 3 4 5 6 7 8 9 10
LOW MODERATE HIGH

7. How would you describe the pain/discomfort.

() BURNING () TINGLING () NUMBNESS () ACHING () SHARP

8. Please *circle* below the area of your body you are seeking treatment for today.

Other:





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9. Are you currently under medical supervision?

() YES () NO

If yes, please explain who and why _____

10. Are you currently taking any medication?

() YES () NO

If yes, please list _____

11. Do you currently see other health care practitioners?

() YES () NO

If yes, who and how often? _____

12. Please check any condition listed below that applies to you:

- () Contagious Skin Condition _____ () Phlebitis _____
- () Open Sores or Wounds _____ () Thrombosis/Blood Clots _____
- () Heart Attack/Stroke _____ () Rheumatoid Arthritis _____
- () Accident/Injury/Whiplash _____ () Osteoarthritis/Osteoporosis _____
- () Recent Fracture/Surgery _____ () Epilepsy _____
- () Plates/Screws/Implants _____ () Headaches/Migraines _____
- () Artificial Joint _____ () Cancer _____
- () Sprains/Strains _____ () Diabetes _____
- () Current Fever/Nausea _____ () Neuropathy _____
- () Swollen Glands _____ () Swelling/Inflammation _____
- () Allergies/Skin Sensitivity _____ () Fibromyalgia _____
- () Decreased Sensation _____ () TMJ Disorder _____
- () High/Low Blood Pressure _____ () Carpal Tunnel Syndrome _____
- () Circulatory Disorder _____ () Tendinitis/Bursitis _____
- () Varicose Veins/Bruising _____ () Pregnant? If yes, how many months? _____
- () HIV _____ () Breast Feeding _____

13. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effect massage session for you?

I, _____ hereby release the massage therapist and **360 Wellness** from any and all liability from problems arising from the therapy as a result of information not given or incorrectly given in this record. ***I also accept that I will be charged 50% for any appointments that are missed or cancelled without 24 hours notice.***

Signature of Client or Guardian

Therapist Signature

Date

Date