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:

_____

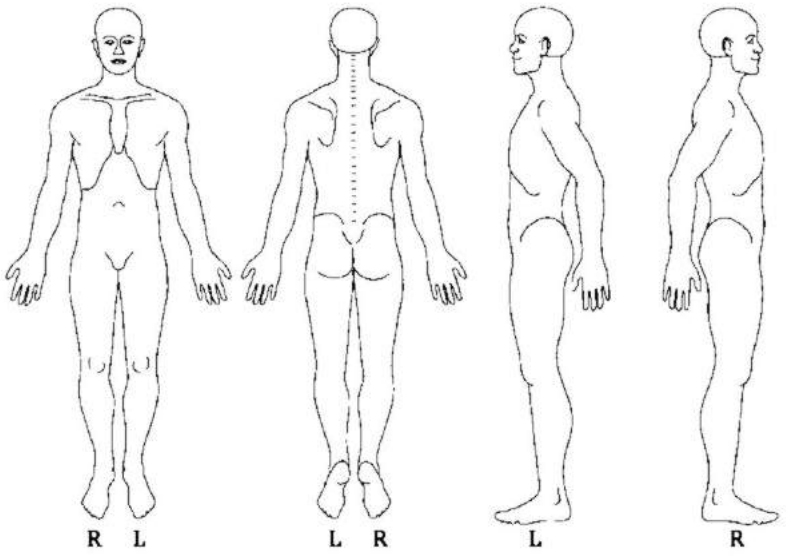
_____

_____

_____

_____

_____



360 WELLNESS MASSAGE THERAPY - INTAKE

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 _____
( ) Open Sores or Wounds _____
( ) Heart Attack/Stroke _____
( ) Accident/Injury/Whiplash _____
( ) Recent Fracture/Surgery _____
( ) Plates/Screws/Implants _____
( ) Artificial Joint _____
( ) Sprains/Strains _____
( ) Current Fever/Nausea _____
( ) Swollen Glands _____
( ) Allergies/Skin Sensitivity _____
( ) Decreased Sensation _____
( ) High/Low Blood Pressure _____
( ) Circulatory Disorder _____
( ) Varicose Veins/Bruising _____
( ) HIV _____

( ) Phlebitis _____
( ) Thrombosis/Blood Clots _____
( ) Rheumatoid Arthritis _____
( ) Osteoarthritis/Osteoporosis _____
( ) Epilepsy _____
( ) Headaches/Migraines _____
( ) Cancer _____
( ) Diabetes _____
( ) Neuropathy _____
( ) Swelling/Inflammation _____
( ) Fibromyalgia _____
( ) TMJ Disorder _____
( ) Carpal Tunnel Syndrome _____
( ) Tendinitis/Bursitis _____
( ) Pregnant? If yes, how many months? _____
( ) 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**