

Massage Therapy Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Ph.: _____ Cell Ph.: _____

Occupation: _____ D.O.B. _____

Email Address: _____

Emergency Contact Name: _____ Ph. _____

Have You Received Massage Before? Yes No If Yes, How Long Ago? _____

What Results Would You Like To Achieve With Our Work? Please Circle!

Relaxation Pain Relief Stress Reduction Injury

Illnesses / Accidents/ Injuries Still Affecting You: _____

Surgeries: _____

Please Mark Any Of The Following You've Had Or Now Have:

- | | |
|--|---|
| <input type="checkbox"/> Bone Or Joint Disease | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Tendonitis / Bursitis | <input type="checkbox"/> Phlebitis / Varicose Veins |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Jaw Pain / TMJ | <input type="checkbox"/> High / Low Blood Pressure |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> Spinal Problems | <input type="checkbox"/> Thrombosis / Embolism |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |
|
 | |
| <input type="checkbox"/> Breathing Difficulty / Asthma | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Allergies: Specify _____ | <input type="checkbox"/> Herpes / Cold Sores |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | |

- | | |
|--|--|
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Numbness / Tingling | <input type="checkbox"/> Irritable Bowel |
| <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | |
|
 | |
| <input type="checkbox"/> Pregnant | |
| <input type="checkbox"/> Ovarian / Menstrual Problems | |
| <input type="checkbox"/> Prostate | |
|
 | |
| <input type="checkbox"/> Cancer / Tumors | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Bladder / Kidney Ailment | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches / Migraines |
| <input type="checkbox"/> Drug / Alcohol / Caffeine / Tobacco Use | <input type="checkbox"/> Anxiety / Stress |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Contact Lenses (Hard or Soft) |

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, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments I might have.

I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.

I agree to give a 24 hour notice for a scheduled session I cannot keep. I am aware that I may be charged a \$20 fee for any missed sessions or sessions that I am unable to give a 24 hour notice to cancel or reschedule.

Signature

Date

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