# Massage Therapy Medical Intake

Name: _____ Referred By: _____
Home Phone: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____
Have you ever had a professional massage before? _____ If so, how often? _____
Do you have any allergies that I need to be aware of? This can include oils, discomfort to scents, etc: _____

## Health History

Describe any surgeries you have had: _____
List any conditions currently monitored by a health care provider: _____

_____

Please list any medications and/or supplements you are taking: _____

_____

Please note all current and previous conditions:

| | | | | | |
|---|---|---|---|---|---|
| Headaches | Y | N | Poor Circulation | Y | N |
| Migraines | Y | N | Thyroid dysfunction | Y | N |
| Flu or cold symptoms last 48 hours | Y | N | Diabetes | Y | N |
| Scoliosis | Y | N | Cancer/tumors benign or malignant | Y | N |
| Blood Clots | Y | N | Currently pregnant | Y | N |
| Sleep Problems | Y | N | Low Back, hip or leg pain or Numbness | Y | N |
| Fatigue | Y | N | | | |
| Arthritis | Y | N | Neck, shoulder or arm pain Or numbness | Y | N |
| Osteoporosis | Y | N | | | |
| Sciatica | Y | N | Varicose Veins | Y | N |
| Heart Disease | Y | N | Tendonitis/Bursitis | Y | N |
| High/low blood Pressure | Y | N | Spasms/Cramps | Y | N |
| Disc Problems | Y | N | Broken Bones | Y | N |

Please provide any further information for any conditions listed above: _____

_____

What are you looking to gain out of your massage session?

Please check the areas of the body you give permission to receive massage:

☐ Back ☐ Legs ☐ Arms ☐ Neck ☐ Head ■ Face

☐ Buttocks ☐ Abdomen ■ Chest ☐ Feet

List stress reducing activities you participate in, please include frequency:

_____

_____

Do you exercise?_____ If so, describe what activities you partake in. Please include frequency

_____

Do you have any difficulty lying on your front, back or side? Yes No

If yes, please explain: _____

Draping will be used during the session – only the area being worked on will be uncovered.

I, _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Use of tools such as cupping, Instrument Assisted Soft Tissue Mobilization (IASTM) tools, essential oils, t-bars and other such items could be used during the course of the session. I have been explained the use of tools, the possible positive and negative effects of these tools and agree to their use. I understand that these treatments could leave skin markings that are normal in the course of treatment. I will report any discomfort during the treatments or contact Amie Kern as massage therapist if any questions or concern arise after treatments. I also have been given home instruction after these treatments to assist in further home care after the use of tools and massage. If I am not comfortable with having these tools used, I will let my therapist know.

Signature of client _____Date:_____

Signature of Massage Therapist_____Date: _____