Client Name:

Massage Intake Form

Thank you for coming. Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire. All your information will be confidential. If you have questions, please ask.

Contact Information Today's Date: _____/_____/_____

Name:_____ Sex: F ☐ M ☐ DOB: _____/_____/_____ Age:____
Street:_____ Email Address:_____
City:_____ State:_____ Zip:_____ Phone Number:_____
Occupation:_____ Employer:_____
Emergency Contact:_____ Phone:_____
How did you find out about us? Walk By ☐ Friend/Relative ☐: _____ Website ☐ Internet Search Engine ☐ Doctor Referral ☐:_____ Other ☐: _____

Major Health Complaint(s)

Please list in order of significance to you and **check which you would like us to focus on today**.
1. ☐_____ 4. ☐_____
2. ☐_____ 5. ☐_____
3. ☐_____ 6. ☐_____
When did the checked problem begin?_____
What kind of treatments have you tried?_____
What makes this problem worse?_____ Better?_____
Is there anybody in your family with the same problem?_____
Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

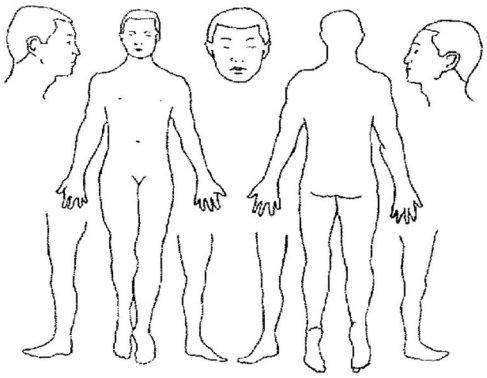
_____
_____

Known allergies (food, medications, or other):_____
Significant trauma (car accident, sports injuries etc.):_____
Immunizations: ☐ In the past ☐ Never ☐
Hospitalizations/Surgeries (procedures and dates):_____
Do you have any sexually transmitted diseases? _____
Do you have a history of frequent antibiotic use? Please Describe._____
Allergy shots? Currently ☐ In the past ☐ Never ☐

Current Health & Lifestyle
Do you smoke? Y ☐ N ☐ If yes, how long?_____
Do you exercise? Y ☐ N ☐ If yes, how many times per week?_____
Do you sit in traffic/commute as a daily routine? Y ☐ N ☐
How many hours do you sleep at night (average)?_____ When do you usually go to bed?_____

Client Name:

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:	
X	Sharp / Stabbing
P	Pins and Needles
D	Dull / Aching
N	Numbness

Please rate your **current** level of pain: (Very mild) **1 2 3 4 5 6 7 8 9 10** (Very severe)

Medications and Supplements

Medications you are currently taking (please include prescription medicines, vitamins, supplements, over the counter drugs, herbal supplements, etc.):

_____

_____

_____

Patient Signature Date