MASSAGE INTAKE *(Please **COMPLETE EVERY SPACE**)*

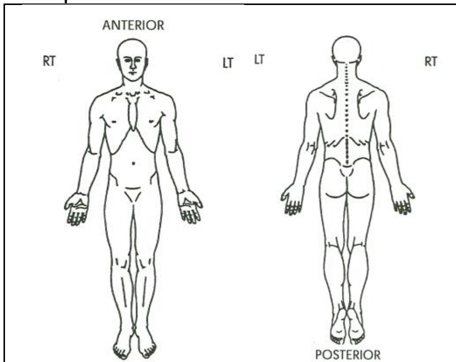
FILE #	DOI:

LAST NAME FIRST NAME MI	SOCIAL SECURITY NUMBER:
ADDRESS	EMPLOYER/ SCHOOL ☐FT ☐PT ☐RET ☐UNEMP
CITY STATE ZIP CODE	EMPLOYER/ SCHOOL ADDRESS
HOME PHONE ( ) CELL PHONE ( )	OCCUPATION WORK PHONE ( ) EXT.
E-MAIL	NAME OF SPOUSE (or responsible party if minor) DATE OF BIRTH MM DD YYYY / /
DATE OF BIRTH MM DD YYYY / / **SEX** **M/ F** MARITAL STATUS ☐ Sing. ☐ Mar. ☐ Div. ☐ Wid.	EMERGENCY CONTACT NAME RELATION TO YOU
Who may we thank for referring you?	EMERGENCY PHONE ( )

1. HEALTH HISTORY

Height: _______ Weight: _______

Mark an X on the picture where you have a complaint:



Place a mark on "Yes" or "No" to indicate if you have any of the following:

Acne	□ Yes □ No	Heart Disease	□ Yes □ No
Allergies	□ Yes □ No	Diabetes	□ Yes □ No
Arthritis	□ Yes □ No	Asthma	□ Yes □ No
High Blood Pressure	□ Yes □ No	Cancer	□ Yes □ No
Epilepsy or Seizures	□ Yes □ No	Blood Disorder	□ Yes □ No
Claustrophobia	□ Yes □ No	Seborrhea	□ Yes □ No
Varicose Veins	□ Yes □ No	Surgery	□ Yes □ No
Contagious Disease	□ Yes □ No	Pregnant or Nursing	□ Yes □ No
Contact Lenses	□ Yes □ No	Wear Dentures	□ Yes □ No
Pacemaker	□ Yes □ No		

If you suffer from any other conditions or need to explain the above: _____________

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EXERCISE	WORK ACTIVITY	HABITS	
□ None	□ Sitting	□ Smoking	Packs/ Day ___________
□ Yes, ___days /week	□ Standing	Type _________	How long? _________ years
Type of exercise:	□ Light Labor	□ Alcohol	Drinks/ Week __________
____________________	□ Heavy Labor	□ High Stress Level	Reason ______________
____________________			

CONSENT TO TREAT & RECORDS RELEASE *(Please **read** and **sign**)*

I hereby state that the information on this page is true and correct. I hereby authorize the Massage Therapist to treat (my condition/ the condition of my child or legal ward) as he/ she deems appropriate. I understand that the intent is to improve the function of my body and mobilize the energy and that the work is not represented as a substitute for medical care.

It is understood and agreed the client file is property of this office, being on file where they may be seen at any time while a client of the massage therapist.

I hereby authorize the release of any medical or other information necessary to process my claim for medical benefits. I authorize my insurance companies to issue payment directly to this Office. The Massage Therapist will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I agree to be on time for my appointments and to accept financial responsibility for my **appointments missed or cancelled** without 24 hour notice. If I do not meet this agreement, I will be fully responsible for **paying $40 to this office**. (**NOTE:** Insurance will not pay for this)

_____________________ X_______________________________________

Date Patient, or Parent/ Legal Guardian for patient under 18 years of age

Additional Notes: ____

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