Diana Remaley
Massage Therapy

Client Intake Form

Name:_____ Date:_____
Address (Street, city, state):_____
Phone:_____ Date of Birth: _____
Email:_____
Occupation:_____
Posture assumed most of the day (standing/seated/etc.):_____
Are you presently experiencing any pain or discomfort?_____
_____
Have you previously received a professional massage? _____
(Describe any relevant details)_____
How did you hear about this office? (Website, referral, etc.) _____

Habits:
Exercise_____
Tobacco_____Alcohol_____Caffeine_____
Sleep_____Drugs (non-prescription)_____

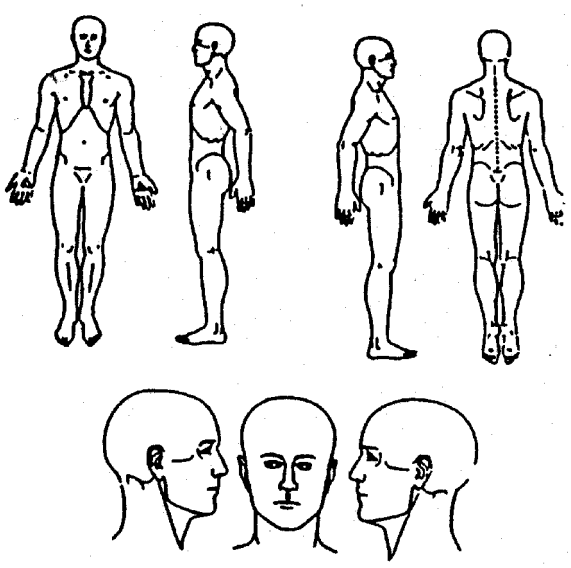
Do you experience any difficulty lying on your back or stomach? _____

Have you consumed any narcotics in the past 24 hours?
_____

Are you currently taking any prescription medication?
_____
Please list:_____

Please describe the condition for which it was prescribed:
_____

Please mark any area where you are experiencing pain or discomfort



Medical History

Please indicate if you are presently experiencing or have experienced any of the following conditions:
_____Skin condition (acne, rash, psoriasis, allergies, warts, Botox, other) _____
_____All allergies: Please specifically list _____
_____Diabetes
_____High or low blood pressure
_____Asthma
_____Cancer (Please list type and date) _____
_____Thyroid condition (please specify)_____
_____Lymphatic condition (swollen glands, lymphedema, lymphoma, etc.)
_____Recent injury or accident (whiplash, sprain, strain, etc.)

Over Please

_____Circulatory Condition (heart disease, varicose veins, phlebitis, arrhythmia, atherosclerosis, etc.)
_____Neurological Condition (sciatica, numbness/tingling, stroke, epilepsy, etc.)
_____Joint problems, pain, stiffness, (arthritis, gout, hypermobility, etc.)
_____Bone condition (previous fracture, cancer, etc.)
_____Headaches (migraines, tension, PMS, cluster, sinus, etc.)
_____Emotional difficulties (depression, anxiety, etc.)
_____Stress
_____Digestive disorders (Crohn's disease, IBS, constipation, etc.)
_____Previous surgery (please list type and date) _____
_____Any other medical condition (please specify) _____
_____Are you pregnant?

Primary Health Care Provider:_____
PCP Address:_____
PCP Phone:_____
Permission to Contact PCP? If yes, please initial_____

Emergency Contact Name/Relationship:_____
Emergency Contact Phone:_____

Agreements and Acknowledgments

Client understands that massage therapy provided is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Health Care Provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

Client understands that there are remote risks associated with massage therapy. Client acknowledges that massage therapist is not liable for any injury resulting from unreported conditions and/or concerns.

Client acknowledges that massage therapy performed is strictly non-sexual and that proper draping techniques will be observed at all times. Client also acknowledges that appropriate hygiene will be maintained at all times in office.

Client has informed the massage therapist of all my known physical conditions, medical conditions and medications, and will keep the massage therapist updated on any changes.

I have read and understand this document.

Client
Signature_____ Date_____