Eva Blum, CCST— Massage Intake Form

Date: _____

_____ Name	_____ Date of Birth
_____ Address	_____ Occupation
_____ City, Province Postal Code	_____ Telephone
_____ Emergency Contact Name	_____ Emergency Phone #

Are you currently under the care of a health professional? Yes ____ No ____.

_____ Name of Professional	_____ Specialty / Area of Practice	_____ Phone

What are your treatment goals for today's session? (i.e., relaxation, get rid of pain in the left shoulder, etc.)?

_____

_____

_____

_____

List names of any medications you are taking:

_____

_____

_____

Accidents, Injuries, or Surgeries. Provide dates, descriptions and treatments:

_____

_____

_____

_____

_____

Are you currently experiencing any of the following? Check any of the below that apply:

___ Pregnancy	___ Inflammation	___ Flu / Cold / Fever
___ Infection	___ Contagious Disease	___ Headache

What are your daily/weekly physical activities?

_____

_____

_____

Complete second side of intake form.→

Do you have or have you had any of the following?

___ AIDS/HIV
___ Anemia
___ Arthritis/Gout
___ Broken Bones
___ Bursitis / Joint Disorders
___ Cancer
___ Chronic Illness / Pain
___ Diabetes
___ Digestive Problems
___ Disc Problems
___ Diverticulitis
___ Epilepsy
___ Fibromyalgia
___ Headaches/Migraines
___ Heart Attack
___ Hepatitis
___ High/Low Blood Pressure
___ Insomnia
___ Multiple Sclerosis
___ Numbness / Tingling
___ Respitory/Lung Problems
___ Sciatica
___ Skin Allergies
___ Spinal Injury
___ Stroke
___ Tendonitis
___ Thoracic Outlet Syndrome
___ TMJ / TMD
___ Tuberculosis
___ Tumors
___ Varicose Veins
___ Whiplash
___ Other

Please explain any item checked above:

_____

_____

_____

_____

_____

_____

Please read and sign below to indicate agreement:

1. The information on both sides of this Massage Intake Form is complete and accurate to the best of my knowledge.

2. I have listed all known medical conditions and physical limitations and will inform the massage therapist of any future changes in my information.

3. I understand that a massage therapist does not diagnose medical conditions or injuries and I authorize the massage therapist to obtain information from my primary health care providers.

4. I am responsible for payment at time of treatment unless other arrangements are made.

5. I agree to pay for any appointment time missed or cancelled **with less than 24 hours' notice.** If I arrive late, the massage therapist and I will make efficient use of the time remaining.

6. I am a partner in my treatment. I will give feedback on the treatment and alert the massage therapist to areas requiring special attention.

_____ _____

Client Signature Date