Medical Massage Therapy
Intake Form

5151 Reed Rd., Suite 131-C, Columbus, Ohio 43220, 614.519.5461

Personal Information

Name: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Daytime Phone: (_____) _____ Evening Phone: (_____) _____
Email Address: _____ DOB: _____
Emergency Contact: _____ Phone: (_____) _____

Massage Experience

How did you hear about us? _____
Have you ever had a professional massage before? Y / N

If yes, when was your last massage?_____

What type of massage? (ex. Swedish, Deep Tissue, etc) _____

What results do you want from your massage sessions?
_____

Prioritize the areas of your body that you would prefer massaged?
_____
What type of pressure do you like? (Please Circle) Light----Medium----Firm----Deep

Are you uncomfortable with any of the following areas to be massaged:
Gluteal Region (Y/N) Pectoral Region (Y/N) Face/Scalp (Y/N) Feet (Y/N)

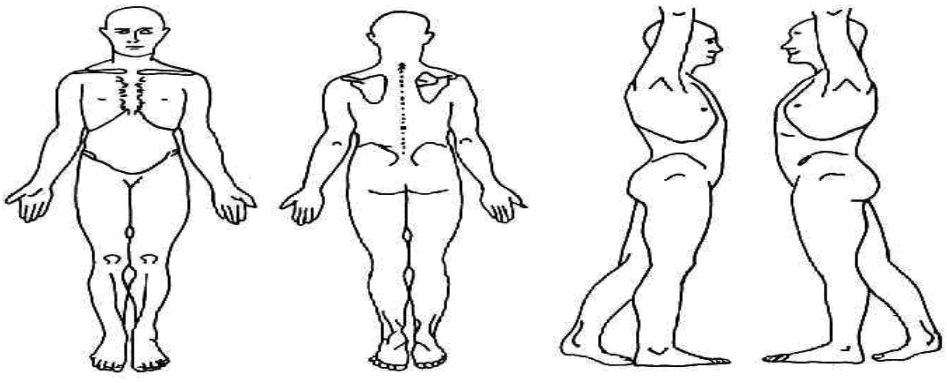
Health History

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

Please list any injuries/accidents/illnesses still affecting you:
_____

Please list any surgeries and explain:
_____

Please identify the areas of concern on the chart below:



Are you currently seeing a medical practitioner? _____ If yes explain: _____
_____
List any stress reduction and exercise activities you participate in and frequency:
_____
_____

Health History

Please indicate any Present (P), Past (X), or Reoccurring (C) conditions:

____ ADD/ADHD
____ Allergies
____ Alzheimer's disease
____ Anxiety Disorder
____ Arthritis
____ Osteoarthritis
____Rheumatoid Arthritis
____ Athletes foot
____Asthma
____Blood clot/deep vein thrombosis
____Phlebitis/Embolism
____Broken or fractured bones
____ Bursitis
____ Cancer
-- Location: _____
-- Treatment: _____
-- Remission? Y/N
____ Carpal Tunnel Syndrome
____ Cerebral Palsy
____ Chronic Fatigue Syndrome
____ Contagious condition
____ Chrohn's disease
____ Depression
____ Diabetes Type I
____ Diabetes Type II
____ Divrticulitis
____ Eczema
____ Epilepsy
____ Epstein Barr
____ Fertility Concerns
____ Fibromyalia
____ General Fatigue
____ Gout
____ Headaches
--Types: _____
-- Frequency: _____
____ Hearing Impairment
____ Heart Condition
____ Herpes/ Shingles
____ High/ Low Blood Pressure
____ High/ Low Cholesterol
____ HIV/AIDS
____ Infection
____ Lupus
____ Lymphedema
____ Mononucleosis
____ Multiple Sclerosis
____ Muscular Dystrophy
____ Numbness/ Tingling
____ Osteoporosis/Osteopenia
____ Pain
--Location: _____
--Muscular or Joint: _____
-- Chronic? Y/N
____ Paralysis
____ Parkinson's disease
____ Pregnancy
____ Psoriasis
____ Rash
____ Sciatica
____ Scoliosis
____ Seizure
____ Sleeping problems
____ Spasms/ Cramping
____ Strain/ Sprain
____ Stroke
____ Tendonitis
____ Thyroid issues
____ TMJ/ Jaw Pain
____ Tumor
--Location: _____
--Malignant or Benign? _____
____ Varicose Veins
____ Visually impaired
____ Other: _____

Release Form

By signing this, I agree that I have answered all questions to the best of my knowledge and that I will inform the therapist of any changes in my condition or medication. If I experience any pain/discomfort or would like the pressure adjusted, I will inform the therapist immediately.

I understand that a massage therapist cannot diagnosis any illness, disease, or any physical or mental disorders nor can the therapist prescribe any medication and that nothing said in a session should be construed as such. I understand that massage therapy is intended to work in conjunction with my health care, not act as a substitute for medical examination. I understand that it is my responsibility to consult a physician for any ailments I may have.

I understand that massage therapy is a therapeutic measure used to reduce stress, muscular tension, and pain. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made with my treatment I will inform the therapist, so he/she may direct me to another treatment. I also understand that massage therapy is non-sexual in nature and any advancement made will terminate the massage.

I agree that I am of legal age (18 years old) and that if I am not, I agree to have my parent or guardian sign a parental/guardian release form before treatment.

I understand that certain conditions or medications may contraindicate (not permit) massage or may require the use of alternate techniques or pressure. I respect the decision of the massage therapist and am fully prepared to reschedule the massage for a later date if requested by the massage therapist. I also understand that massage may be advisable by my physician, but not by a massage therapist. In that event, I agree to provide a written agreement from my physician before proceeding with treatment.

Print Name: _____

Signature:
_____

Date: _____