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# Massage Therapy Intake Form

## Gardens Wellness Center

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Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

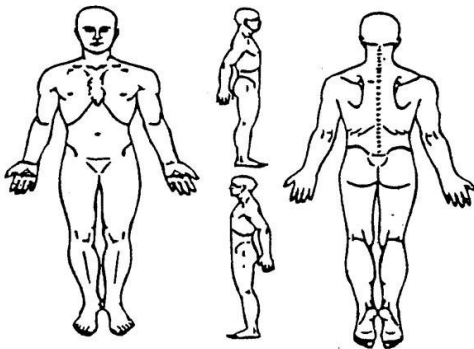
Phone (home) \_\_\_\_\_ (work/cell) \_\_\_\_\_ email \_\_\_\_\_

Occupation \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Emergency contact name & number \_\_\_\_\_

Referred by: \_\_\_\_\_

Are you currently in pain or experiencing any discomfort? If so, please briefly explain and indicate those areas below. Mark X for pain and 0 for discomfort: \_\_\_\_\_



Describe any chronic pain/tension \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Are you currently under the care of a physician, chiropractor or alternative medicine practitioner? If yes, what are you being treated for? \_\_\_\_\_

Please list any medications (prescription or non-prescription), vitamins and supplements you are currently taking: \_\_\_\_\_

What specific areas would you like for me to focus on or stay away from? \_\_\_\_\_

Are there any areas you do NOT like massaged (i.e. feet, stomach, head, face)? \_\_\_\_\_



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What do you hope to accomplish with this massage? (i.e. relaxation, decrease back pain, increase flexibility, etc.) \_\_\_\_\_

How frequently and for how long do you exercise and what do you do? Include sports, Pilates, yoga, gardening and/or other physical activities: \_\_\_\_\_

How many hours of sleep do you receive each night (approximately)? \_\_\_\_\_

What is your sleeping position? \_\_\_\_\_

Check one: Are you right-handed  or left-handed

What is your daily intake of: Water: \_\_\_\_\_ Caffeine: \_\_\_\_\_ Alcohol: \_\_\_\_\_

Please check any of the following that apply to you – in the **PAST (P) OR CURRENTLY (X)** :

Condition/Complaint	Past	Present	Condition/Complaint	Past	Present
Headaches			Pins and Needles in arms, legs, Hands or feet		
Type:			Neurological problems		
Asthma			Spinal Problems		
Cold Hands/feet			Herniated/Bulging Discs		
Swollen ankles			Osteoarthritis		
Sinus Conditions			Arthritis		
Frequent Colds			Anxiety		
Allergies (specify above)			Depression/Panic		
Loss of smell/taste			Sleep Disturbance		
Skin Conditions			Loss of Memory		
Painful/Swollen Joints			Whiplash		
Auto-immune disorder			Bruise Easily		
Cancer			Constipation/Diarrhea		
Varicose Veins			Contact Lenses		
Blood Clots/DVT			Dentures/Partials		
Heart Problems			Hemorrhoids		
Pacemaker			Artificial/Missing limbs		
High/Low BP			Muscular Tension		
Diabetes			Sciatica		
Epilepsy or Seizures					
Fainting Spells					

Further explanation of any condition or other information: \_\_\_\_\_

The following sometimes occurs during massage; they are normal responses to relaxation. Trust your body to express what it needs:

- ☞Need to move or change positions
- ☞Sighing, yawning, change in breath
- ☞Stomach gurgling
- ☞Emotional feelings and/or expressions
- ☞Movement of intestinal gas
- ☞Energy shifts
- ☞Falling asleep
- ☞Memories

- I understand the treatment here is not a replacement for medical care.
- As such, the therapist/practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform any spinal manipulations (unless specified under his/her professional scope of practice)
- I understand that the treatment is not a substitute of medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have.
- I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.
- I understand that payment is due at the time of treatment unless arrangements have been made otherwise.
- I understand the therapist/practitioner is subcontractor and work out of Gardens Wellness center.
- **I agree to give at least 24 hours notice of cancellation of appointment, otherwise will be expected to pay for session PLEASE INITIAL \_\_\_\_\_**

Client signature \_\_\_\_\_ Date \_\_\_\_\_