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## Massage Intake Form

Please take just a few moments to fill out this questionnaire. This will help us serve you better!

### Basic Data

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

Address: \_\_\_\_\_ City: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

How did you hear about us?  Fax  Newspaper  Coupon  Won Free Massage  
 Referral from \_\_\_\_\_  Other \_\_\_\_\_

### Health History

1. Have you ever received a professional massage or other bodywork?  Yes  No
2. What reason are you receiving a massage today? Please be specific. \_\_\_\_\_
3. Are you interested in finding out more information about the Rub Club?  Yes  No
4. If you exercise, how often and what type? \_\_\_\_\_
5. Please check if you have had or are currently experiencing any of the following:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Communicable Diseases	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Immunosuppression
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Neurological Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Location: _____	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Pregnancy ___ # of months
<input type="checkbox"/> Treatment: _____		
<input type="checkbox"/> Fractures/Broken Bones	<input type="checkbox"/> Fractures/Broken Bones	<input type="checkbox"/> Respiratory/Lung Disease
<input type="checkbox"/> Car Accident(s)	<input type="checkbox"/> Inflammation/Swelling	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Other: _____
6. Please list any serious illnesses, hospitalizations or surgeries: \_\_\_\_\_  
\_\_\_\_\_
7. List any medications, herbs, or supplements that you are taking at this time: \_\_\_\_\_  
\_\_\_\_\_
8. When did your pain begin? \_\_\_\_\_
9. Does your pain travel to another part of the body? \_\_\_\_\_
10. Rate your current pain level from 0 to 10 with 0 indicating no pain: \_\_\_\_\_

## Consent

I understand that massage or bodywork is not a substitute for medical examination, diagnosis, or treatment and that I should see a qualified medical specialist for mental or physical ailments.

If I experience pain or discomfort during a session, I will inform the massage therapist so that pressure and area of touch may be adjusted.

Because massage therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions. I agree to keep the massage practitioner updated as to any changes in my medical profile.

By signing this form, I consent to massage therapy and intend this consent to cover the entire course of my massage therapy treatments. I understand that I may discontinue a session or sessions at anytime.

Remember that at anytime during the course of our work together, I cannot make any diagnosis. Any suggestions made during your session are only suggestions.

I have read the above and consent and understand what it says.

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Patient Signature or Legal Guardian

Date