Massage Therapy/Energy work Intake

Name:____ Date:_______________

Address:____

Mobile Phone Number:____

Email Address:____

DOB:_______________ Age:_____ May we contact you and leave a message:___________________

Emergency Contact Mobile Phone number and Email Address:_________________________________

____

Previous Experience with Massage:____

Referred by:____

Primary reason for appointment:____

What do you want from Massage Therapy:____

Do you think you need your doctor's okay for massage therapy? Yes No (please circle)

Please circle or list additional current possible conditions you may have:

(abdominal or digestive problems, acute pain/broken bones/bruises, abrasions/scraps/recent injuries, allergies, arthritis, asthma or lung conditions, autoimmune troubles, blood clots/swelling, bone/connective tissue/joint concerns, cancer and/or tumors and appliances, diabetes, fatigue, headaches/migraines/dizziness, hearing problems or deafness, heart/circulatory problems and appliances, hernia, high/low blood pressure, infectious diseases/fungal, injuries on face or head, jaw pain/TMJ problems, lymphatic/immune system issues/Lupus, muscle/bone injuries, muscle/joint pain, nervous system/numbness or tingling, pregnancy, rashes/athletes foot, sensitivities, sinus/eye/throat problems, skin problems/hives/sores, sleep difficulties, spinal column disorders, sprains/strains, tendonitis, tension/stress, varicose veins, etc.):____

Please list pertinent surgeries and approximate dates:____

Please list any pertinent medications (including hormonal or topical):____________________________

Please share any birth or developmental concerns:____

Please list any safety concerns you may have for yourself:_____________________________________

____

Would you rather not face down on the table? Yes I am not concerned (circle 1)

Please let us know any additional physical, mental, emotional, and/or spiritual concerns you may wish the therapist keeps in his/her/their awareness:____