

# Center for Integrative Medicine

## Massage Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Male  Female Date of Birth: \_\_\_\_\_ Referred by/ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation(s): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ PhoneNo: \_\_\_\_\_ Relationship: \_\_\_\_\_

What are your concerns/symptoms? \_\_\_\_\_

When did you first notice this concern? \_\_\_\_\_

What brought it on? \_\_\_\_\_

What aggravates the condition? \_\_\_\_\_

What activities relieve the condition? \_\_\_\_\_

Are the symptoms constant or intermittent? \_\_\_\_\_

Has a physician given you a diagnosis? Yes  No  What is the diagnosis? \_\_\_\_\_

Have you ever had an accident? Yes  No  Describe the injuries including dates, location on body, and treatments

(more space on the back of form): \_\_\_\_\_

Last Surgeries and dates: \_\_\_\_\_

List any medical conditions that are currently being treated: \_\_\_\_\_

List any prescription medication (more space on the back of form): \_\_\_\_\_

List any over the counter medication (more space on the back of form): \_\_\_\_\_

List any herbs/supplements, homeopathic (more space on the back of form): \_\_\_\_\_

Do you have tension or soreness in a specific area? \_\_\_\_\_

Do you have numbness, tingling, or stabbing pain? Yes  No  Please describe: \_\_\_\_\_

Are you sensitive to touch in a specific area? Yes  No  Please describe: \_\_\_\_\_

Do you have any allergies (include food and topical allergies): \_\_\_\_\_

Please circle any of the conditions you are experiencing or are being treated for:

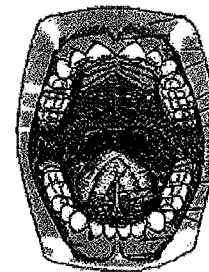
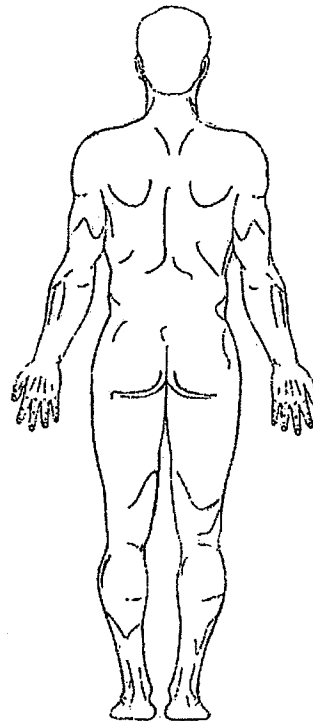
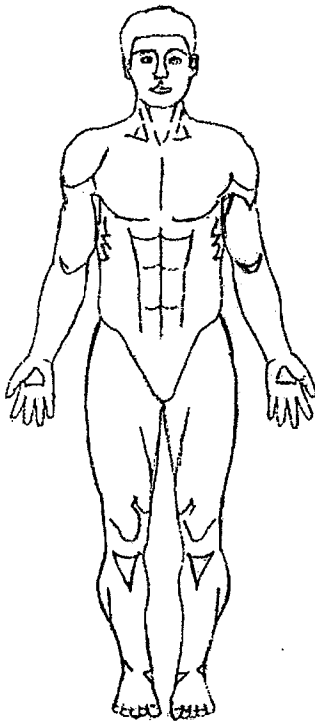
<b>Cardiovascular System</b>
Anemia
Arrhythmia
Blood Pressure high/low
Bruising
Congestive heart failure
Dizziness
Fainting
Heart attack
Pacemaker
Varicose Veins
Other
<b>Digestive System</b>
Colitis
Constipation
Diarrhea
Indigestion
Ulcer
Other

<b>Integumentary System</b>
Itching
Open lesion
Poison ivy/oak
Swelling
Topical Allergies
Warts
Other
<b>Neurological System</b>
Fibromyalgia
Headaches
Migraines
Multiple Sclerosis
Numbness
Seizures
Sleep disturbance
Stroke
Other

<b>Respiratory System</b>
Asthma
Shortness of breath
Sinus pain
Sinus infection
Other
Cancer
Fever
Other
<b>Musculoskeletal</b>
Arthritis OA/RA
Bursitis
Herniated disc
Joint replacements
Spinal curvatures
TMJ
Other

<b>Reproductive System</b>
Pregnancy
Endometriosis
Fibroids
<b>Endocrine System</b>
Diabetes
Thyroid Hyper/Hypo
Menopause
Hot Flash
PMS
Other
<b>Psycho Social</b>
Alcohol abuse
Anxiety
Body dysmorphia
Depression
Eating disorder
Fatigue

Please use the diagram of the human body to mark the areas that are bothering you and rate each area on a scale of 0-10 (10 being most severe) – Use a P for pain and a T for Tension in the muscles.



**Waiver:**

This session is for Massage Therapy only. I certify that the Massage Therapist does not have the ability to diagnose medical conditions, perform physical examination, or treat medical conditions. If there are contraindications to massage a referral to my primary care physician will be made. The therapist cannot perform Chiropractic or Osteopathic Manipulations, Electrical Stimulation, Colonic Irrigation, Ultrasound, or Diathermy.

I will inform the Massage Therapist if the rate of pressure needs to be adjusted or if I experience discomfort or pain.

I will inform the Massage Therapist if I want the session to be terminated at any time and the session will end without question.

I certify that I have filled out this form completely and if during the course of my therapy there are changes in my medical history, I will inform the therapist in a timely manner.

Signed: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_

Date: \_\_\_\_\_