medical & deep tissue massage intake form

name _____ date of birth _____

address _____

city _____ state _____ zip code _____

home phone _____ mobile phone _____

email _____

physician _____ physician's _____

emergency contact(relationship) _____ phone _____

referred by _____

Have you had a professional massage before? ☐ Yes ☐ No

If yes, what type(s) of massage have you had? _____

How long have you been receiving massage therapy? _____

What are your goals with massage therapy? _____

What is the frequency of your massage therapy? _____

Reason for initial visit _____

Height _____ Weight _____

Do you execerise regularly & participate in any sports? ☐ Yes ☐ No

If yes, what type(s) of sports? _____

Do you perform any repetitive movement in your work, sports or hobby? ☐ Yes ☐ No

If yes, describe _____

Are you experiencing any stress in your work, family, or other aspects of your life? ☐ Yes ☐ No

If yes, describe _____

Are you experiencing tension, stiffness, pain or discomfort? ☐ Yes ☐ No

If yes, describe _____

Have you had an injury, surgery or areas of inflammation? ☐ Yes ☐ No

If yes, describe _____

Do you have sensitive skin? ☐ Yes ☐ No

Do you have any allergies to oils,lotions or ointments? ☐ Yes ☐ No

If yes, describe _____

Please list any medications you are currently taking _____

Muscoskeletal

___ Bone or Joint disease
___ Tendonitits/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory

___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Cots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory

___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify:

_____

___ Sinus Problems

Nervous System

___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Reproductive

___ Pregnant, stage ___
___ Ovarian/Menstrual Problems
___ Prostrate

Skin

___ Cosmetic Surgery
___ Rashes
___ Allergies, specify:

_____

___ Athlete's Foot
___ Herpes/Cold Sores

Digestive

___ Irritbale Bowel Syndrome
___ Bladder/Kidney Ailment
___ Colitis
___ Crohn's Disease
___ Ulcers

Psychological

___ Anxiety/Stress Syndrome
___ Other

Other

___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed: _____

Pleas explain any of the conditions marked to your massage therapist.

MOUNTAIN MASSAGE