MPHC Massage Therapy Intake

Full Name: _____ Occupation: _____

Address: _____ E-Mail: _____

City: _____ State: _____ Zip: _____ Birthdate: _____ Add me to e-list for specials: Yes / No
Preferred Phone for confirmation calls: _____ Other Phone: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

- Why are you seeking massage? _____
- What type of pressure do you prefer? light _____ medium _____ deep tissue_____
- What do you hope to accomplish from today's massage? _____

Please answer the following questions accurately.	Yes	No	Please describe.
1. Is this your first massage? If yes, how often do you get massage?			
1. Do you have tension or soreness in a specific area? 2. Are you sensitive to touch in any area?			
1. Describe surgeries, hospitalizations, accidents or injuries. 2. Less than 3 years ago. 3. More than 3 years ago. 4. What kind of care did you receive for your injuries? 5. Do you feel you have recovered from these events?			
1. Do you have any chronic, ongoing pain that you deal with regularly? 2. Describe what activities cause this pain and/or make it worse:			
1. Are you receiving any other type of medical treatment?			
1. Do you have high blood pressure?			
1. Are you epileptic?			
1. Do you have a cardiac disorder			
1. Do you have any circulatory problems?			
1. Do you have any allergies? (to medications or other substances)			
1. Do you have frequent headaches?			
1. Do you have numbness, tingling or stabbing pains anywhere?			
1. Ladies, are you pregnant?			
1. Are you diabetic?			
1. Are there any other health concerns you wish to discuss today?			

Are you wearing contact lenses? _____ Do you exercise? _____ What type? _____ How often? _____
Please list any medication (vitamins, herbs and/or pharmaceutical taken now or at regular intervals (include explanation of what medication is used to treat):_____
Are you currently experiencing any of the following conditions? (Yes/No)
Flu or Cold _____ Inflammation_____ Fever_____ Infection_____ Contagious Disease_____ Warts_____
Rashes_____ Athlete's Foot_____ Open Wound or Sore_____ Impetigo_____ Fungal Infections_____ Other_____

I understand that I must immediately inform the practitioner of any pain or discomfort so the pressure and/or strokes may be adjusted to my comfort level. I understand that massage/bodywork is not a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. Because massage/bodywork may be contraindicated under some circumstances, I affirm that I have stated all of my known medical conditions. I agree to notify the practitioner of any changes in my medical profile before further sessions.

I affirm that I have read and understood this agreement and that all answers above are true to the best of my knowledge.

Client Signature: _____ Date: _____