Massage Works
pain relief clinic

your pain stops here...

NEW CLIENT INTAKE FORM

Please print, complete, and bring with you on your first appointment

Date: ___________________

CONTACT INFORMATION

Name: ____________________ Date of Birth: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: ____________________

Email: ____________________

Home Phone: ____________________ Mobile Phone: ____________________

Occupation: ____________________

Emergency Contact: ____________________ Phone: ____________________

How did you hear about us? ____________________

Preferred contact method

- ❑ Home Phone
- ❑ Mobile Phone
- ❑ Email

MEDICAL BACKGROUND

Have you had a professional massage before? ❑Yes ❑No; if Yes, when? ____________________

Are you pregnant? ❑Yes ❑No; if Yes, due date? ____________________

Are you currently under the care of a physician? ❑Yes ❑No; if Yes, for what condition? ____________________

Please list any medications you are taking and why: ____________________

My PRIMARY health concern is (then check all that apply)

____

1. ❑Mild ❑Moderate ❑Constant ❑Intermittent ❑Disabling
2. ❑↑ w/Activity ❑↓ w/Activity
3. ❑Getting better ❑No change ❑Getting worse

Treatment received ____________________

My SECONDARY health concern is (then check all that apply)

____

1. ❑Mild ❑Moderate ❑Constant ❑Intermittent ❑Disabling
2. ❑↑ w/Activity ❑↓ w/Activity
3. ❑Getting better ❑No change ❑Getting worse

Treatment received ____________________

Daily activities limited by condition(s)

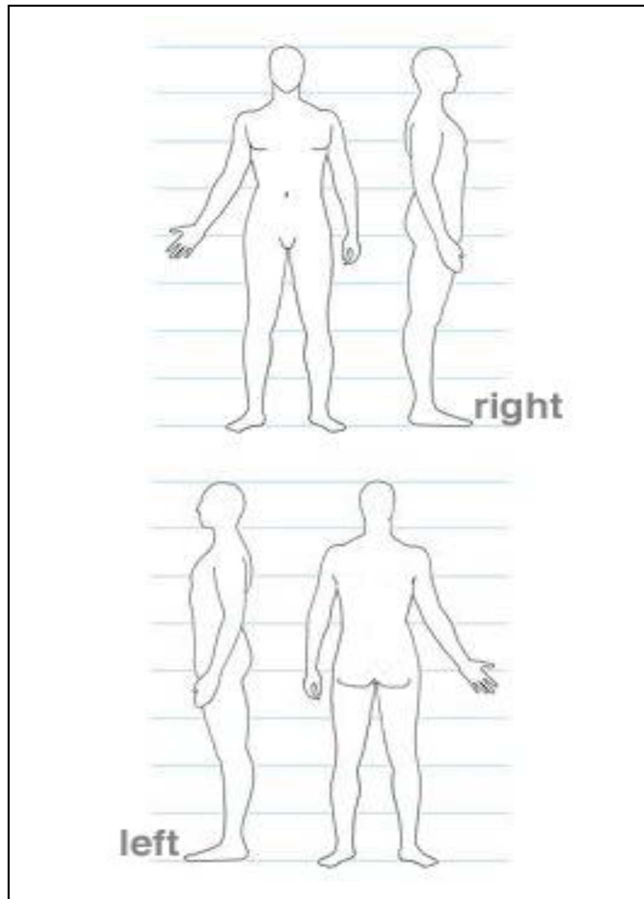
❑ Work: ____________________

❑ Home/Family: ____________________

❑ Sleep/Self-care: ____________________

❑ Social/Recreational: ____________________

Please use the diagram below to circle areas where you are feeling discomfort or pain.



General

	Current	Past
Headaches	☐	☐
Pain	☐	☐
Sleeping disorders	☐	☐
Fatigue	☐	☐
Infections	☐	☐
Fever	☐	☐
Sinus	☐	☐
Other: ______________	☐	☐

Comments: ____________________

____

Skin Conditions

	Current	Past
Rashes	☐	☐
Athlete's foot/warts	☐	☐
Other: ______________	☐	☐

Comments: ____________________

____

Allergies

	Current	Past
Scents, oils or lotions	☐	☐
Detergents	☐	☐
Foods: ______________	☐	☐
Other: ______________	☐	☐

Comments: ____________________

____

Habits

	Current	Past
Tobacco	☐	☐
Alcohol	☐	☐
Drugs	☐	☐
Caffeine, soda	☐	☐

Comments: ____________________

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Cancer/Tumors

	Current	Past
Benign	☐	☐
Malignant	☐	☐

Comments: ____________________

____

Muscles and Joints

	Current	Past
Rheumatoid arthritis	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Scoliosis	☐	☐
Broken bones	☐	☐
Spinal problems	☐	☐
Disk Problems	☐	☐
Lupus	☐	☐
TMJ, jaw pain	☐	☐
Spasms, cramps	☐	☐
Sprains, strains	☐	☐
Tendonitis, bursitis	☐	☐
Stiff or painful joints	☐	☐
Weak or sore muscles	☐	☐
Neck/shoulder/arm pain	☐	☐
Low back/hip/leg pain	☐	☐
Other: ______________	☐	☐

Comments: ____________________

____

Respiratory, Cardiovascular

	Current	Past
Heart Disease	☐	☐
Stroke	☐	☐
Lymphedema	☐	☐
High/low blood pressure	☐	☐
Irregular heart beat	☐	☐
Poor circulation	☐	☐
Swollen ankles	☐	☐
Varicose veins	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Asthma	☐	☐
Other: ______________	☐	☐

Comments: ____________________

____

Nervous System

	Current	Past
Head injuries	☐	☐
Dizziness	☐	☐
Ringing in ears	☐	☐
Loss of memory	☐	☐
Confusion	☐	☐
Numbness, tingling	☐	☐
Shooting pains	☐	☐
Chronic pain	☐	☐
Depression	☐	☐
Other: ______________	☐	☐

Comments: ____________________

____

Digestive/Elimination System

	Current	Past
Bowel problems	☐	☐
Gas, bloating	☐	☐
Bladder/kidney	☐	☐
Prostate	☐	☐
Abdominal pain	☐	☐
Other: ______________	☐	☐

Comments: ____________________

____

Endocrine System

	Current	Past
Thyroid	☐	☐
Diabetes	☐	☐

Comments: ____________________

____

Reproductive System

	Current	Past
Painful menses	☐	☐
Emotional menses	☐	☐
Fibrotic cysts	☐	☐
Other: ______________	☐	☐

Comments: ____________________

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INFORMED CONSENT TO TREATMENT

- I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.
- I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical or emotional disorder nor perform any spinal manipulations.
- I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any physical or mental ailment that I am aware of.
- I agree to give 24-hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the fee for any missed sessions or for sessions that I do not cancel within 24 hours.
- If I experience and pain or discomfort during this session, I will immediately inform the therapist so that the pressure may be adjusted to my level of comfort.

Signed: ____ Date: ____________________