Redefined Health

Massage Therapy Intake

Date _____

Name _____ Birth Date: _____(m) _____(d) _____(y)

Address _____

Home Phone: _____ Cell: _____ Email _____

Occupation: _____

Can we thank someone for referring you?_____ Website Google Other_____

Please indicate conditions you are experiencing or have experienced:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Phlebitis/Varicose Veins
- ☐ Stroke/CVA
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Dizziness
- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ Numbness/Tingling
- ☐ Asthma
- ☐ Emphysema
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Constipation
- ☐ Diabetes
  Type:_____
- ☐ Epilepsy
- ☐ Cancer
  Type/Location:_____
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Skin Condition
  Details:_____
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Warts
- ☐ Open Sores
- ☐ Allergies
  Details:_____
- ☐ Pregnant
  Due Date: _____

Do you have any medical conditions not listed above? Yes No
If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?
Yes No

_____

Have you ever been involved in any motor vehicle accidents? Yes No Year/Date:_____

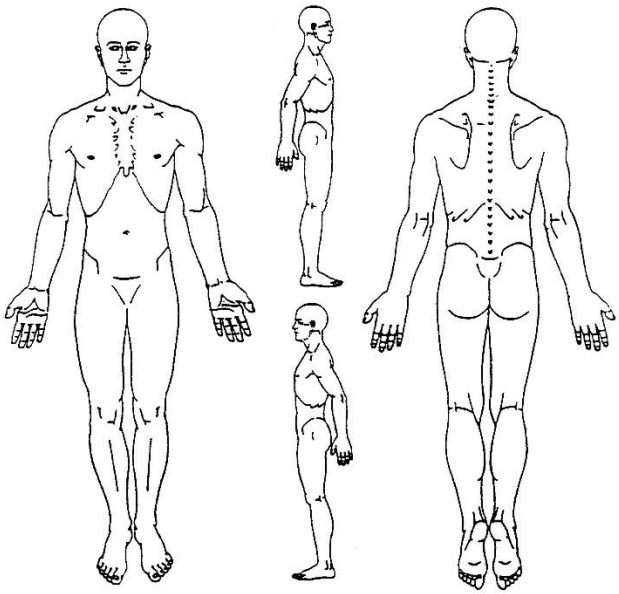
Briefly list any surgeries you have undergone, for what and when.

_____

_____

Redefined Health

Please mark areas which are currently causing you symptoms of discomfort



Have you previously received massage therapy treatments? **Yes** **No**

Please list goals you would like to achieve through massage therapy. (Ex: Relaxation, Decrease Pain, Increase Range of Motion, Maintenance, Achieve Fitness Goal, etc.)

_____

_____

☐ **Please check if you would like a silent treatment.**

Amount of pressure preferred:

Light **Medium** **Deep**

Have you seen any other health care professional(s) for this condition or reason? **Yes** **No**

If yes whom?

_____

Are you presently taking any prescribed medication(s)? **Yes** **No**

If yes, please list the medication(s) and the condition(s) for which it is being used if known.

_____

_____

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

We understand circumstances arise, however, please note a fee may be applied for multiple missed or cancelled appointments within 24 hours.

_____

Signature **Date** **Therapists Signature**