

## MESSAGE INTAKE FORM

Name: _____	Type and Amount of Exercise: _____
Mailing Address: _____ _____ _____	_____ _____
Phone: _____	Goal for Massage: _____ _____
Work Phone: _____	Physician: _____
Date of Birth: _____	E-mail Address: _____
Occupation: _____	Emergency Contact: _____

### Confidential Health Survey

The following confidential information will assist your massage therapist. It will be kept in confidence. If you have any questions about any item, please discuss it with your therapist before the massage begins. Check any of the following symptoms or conditions that you have had or currently have.

- |   |   |   |
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| <input type="checkbox"/> Sinus problems or allergies<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Feet cold<br><input type="checkbox"/> Fainting, dizziness<br><input type="checkbox"/> Under treatment for back pain<br><input type="checkbox"/> Back pain when sitting or lying<br><input type="checkbox"/> Painful or stiff neck<br><input type="checkbox"/> TMJ dysfunction, teeth grinding<br><input type="checkbox"/> Loss of strength in hands<br><input type="checkbox"/> Knee surgery or injury<br><input type="checkbox"/> Female: are you pregnant?<br><input type="checkbox"/> Hip replacement or sciatica<br><input type="checkbox"/> Disk injury or surgery | <input type="checkbox"/> Skin conditions (rash, hive, etc.)<br><input type="checkbox"/> Epilepsy or seizure<br><input type="checkbox"/> Low blood pressure<br><input type="checkbox"/> Painful feet<br><input type="checkbox"/> Numb or tingling feet/legs<br><input type="checkbox"/> Back pain when working<br><input type="checkbox"/> Back pain when standing<br><input type="checkbox"/> Whiplash or other neck injury<br><input type="checkbox"/> Ringing in ears<br><input type="checkbox"/> Arms/hands tingle or numb<br><input type="checkbox"/> Sensitive to fragrances<br><input type="checkbox"/> Abdominal pain or nausea<br><input type="checkbox"/> Cold hands<br><input type="checkbox"/> Neck pain on rotation | <input type="checkbox"/> Infection _____<br><input type="checkbox"/> Inflammation _____<br><input type="checkbox"/> Bursitis _____<br><input type="checkbox"/> Arthritis _____<br><input type="checkbox"/> Headache _____<br><input type="checkbox"/> Back Pain _____ |
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