Massage Patient Intake Form

Name: ____ Date: ________________

1. **What is your goal of your massage therapy?** □ Relaxation □ Therapeutic □ Both

2. **Are you a current patient of Dr. Christina Carter's?** □ Yes □ No
   If yes, may I speak with her concerning your care? □ Yes □ No
   If no, are you currently receiving chiropractic care? □ Yes □ No

3. **Do you currently have a Primary Care Doctor?** □ Yes □ No
   If yes, what is their name or practice: ____

4. **What areas would you like your massage therapy to focus on?**
   ____
   ____

5. **What are your areas of <u>chronic</u> discomfort or pain?** □ None
   ____
   ____

6. **Have you had a professional massage before?** □ Yes □ No

7. **What is your pressure preference?** (mark a range below)

   Extremely Light --------------------------- Medium--------------------------- Very Deep

8. **Areas of your body you would like me to <u>AVOID</u>?**
   □ Scalp □ Face □ Neck □ Pecs □ Low Back □ Glutes □ Feet □ Other:________________

9. **Are you allergic to anything?** □ Yes □ No
   If yes, explain:____

10. **Have you had any surgeries?** □ Yes □ No
    If yes, explain:____

11. **Have you been in a recent accident, injury or fall?** □ Yes □ No
    If yes, please give details: ____
    ____

12. **How talkative do you prefer your massage therapist to be**? (mark a range below)

□ Don't Care Quiet -- Talkative

13. **What medications are you currently taking? and why?**

Medication Name	Reason you take it
________________________________	____
________________________________	____
________________________________	____
________________________________	____
________________________________	____

14. (***Women only***) **Are you pregnant?** □ No □ Yes, _______ months along

If yes, please fill out the "Prenatal Massage Release Form".

15. **Please circle all that apply to you now or in the past and give any needed details:**

□ AIDS/HIV: ____________________________
□ Artificial Joint: ________________________
□ Fibromyalgia: __________________________
□ Scoliosis: ____________________________
□ Shingles: ____________________________
□ Skin conditions: _______________________
□ Varicose Veins: ________________________
□ Bruise Easily: _________________________
□ Diabetes: ____________________________
□ Heart Condition: _______________________
□ Arthritis: ______________________________
□ Open Sores/Wounds: ______________________
□ Blood Clots: ___________________________
□ Broken/Dislocated Bone: _________________
□ Seizures: _____________________________
□ Stroke: _______________________________
□ Whiplash: _____________________________
□ Cancer: _______________________________
□ Headaches/Migraines: ____________________
□ High Blood Pressure: _____________________
□ Autoimmune Disorder (RA, lupus, MS): ______________________________________
□ Other: ____

So we can give you the best possible quality massage please initial beside the following statements:

_______ *(initial here)* This is a therapeutic massage and any sexual remarks or advances will immediately terminate the session and no refund will be provided.

_______ *(initial here)* If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or method of massage may be adjusted to my comfort level.

_______ *(initial here)* I understand that although Massage Therapy can be therapeutic, relaxing, and reduce muscular tension, it is not a substitute for medical examination, diagnosis and/or treatment.

Patient or Guardian Signature: ____

Date:_________________________