Massage Intake Form - CONFIDENTIAL INFORMATION

(Please answer all areas; filling out this form completely will help ensure the best possible care.)

			RENEW Use Only
Name:		Date:	
Do you have any of the [] Cold or Flu [] Bruises [] Contact lenses	[] Open cuts [] Skin rash-where:	[] Infections	Assessment:
[] Cancer/Tumor	[] Blood Clot/DVT [] Lupus [] Liver Disease [] Heart Attack/Condition [] Cortisone Injection: [] Chemo/Radiation Therap	[] Dislocated Joint [] Stroke/CVA [] Neuropathy/Numbness [] Seizures [] Allergies	Condition Precautions:
Is this your first massag	ge?		
If no, when was your la	st massage?		
What is the major comp	plaint or condition you ar	e seeking help for?	
When did this begin? _			
What brought it on?			
What have you done to	get relief?		Drug Precautions:
What positions/activities			
What does this condition	n prevent you from doin	g?	
Is this condition: [] w			
Have you seen a physic	cian for this? Yes / No)	
May we contact your ph	_		
Physician Name / Num	ber:		
Are you now under med	dical/therapeutic treatme	ent? Yes / No	
Must give 24 hour notice	of cancellation or full pag	yment will be expected.	

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Please list all medications and nutritional supplements you are taking:	Notes:
	_
Please list all surgeries in your lifetime:	
	_
	_
Please color in your conditions, scars and injuries etc *PLEASE note any	
areas you'd like to request massaged (face, abdominals, glutes):	
R L L R R	
	-
List other therapies you currently receive:	
Please list any additional comments regarding your health and well-being:	
	_
	_

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Home Address:		
City:	State:	_ Zip:
Mobile Phone Number:		
Email Address:		
Emergency Contact Name:		
Phone Number:	Relationsh	nip:
How did you find us?		
massage therapists do not diagnost or from my therapist is not a substany changes to my health status, appropriete to be a result of massa activity, comment or innuendo vidiscretion based upon the client explanation or prior notice, and I	se or treat disease, and stitute for a physician's medications and therapage therapy as soon as will be tolerated. This t's conditions, therapagree to this policy. Call price of your intended.	plete to the best of my knowledge. I understand that that any care or recommendation I receive in this clinic is care. I take responsibility for alerting my therapist of ites before the session, as well as any and all responses. I become aware of them. I understand that no sexual facility reserves the right to refuse services at their ist's skill set, client attitude or action, etc, without ancellation within 24 hours of scheduled massages may ded session. You may contact me for appointment