

CENTREVILLE PHYSICAL THERAPY

Massage Client Intake Form

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Name: _____ E-mail: _____

Address: _____

Phone: Home: _____ Cell: _____

Referred By: _____ Occupation: _____

Have you previously received massage? _____ When & what type? _____

What are your goals for today's session? _____

Are you currently seeing a health care professional? _____

If yes, please list names & reason/treatment: _____

List any accidents, broken bones, surgeries, muscle sprains or strains & approx. dates

Do you have any ongoing musculoskeletal pain/stiffness? _____

Please check all that apply:

- | | | | | |
|---|--|--|--|------------------------------------|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Edema | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sinus/Ear Issues | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Seizure/Convulsions | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Numbness | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Skin Sensitivity | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> DVT/Clotting Issue | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Contagious Skin Issue | <input type="checkbox"/> TMJ | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Blood Pressure Issue | <input type="checkbox"/> Psych Issue | <input type="checkbox"/> Cold/Flu | <input type="checkbox"/> Balance issues | <input type="checkbox"/> Stroke |

Please elaborate on anything you checked or any additional concerns, if necessary: _____

This information and our sessions are treated with confidentiality. Please give feedback at any time during or after the massage. This communication between you and me during the massage will facilitate a more productive outcome from the session for you.

I, the client, understand that the work done during this massage does not constitute medical treatment and that the massage therapist is not a physician. This session is a form of health and wellness maintenance utilizing the techniques of massage and holistic healing. I, the client, take responsibility for alerting the therapist to my conditions that might affect this work. It is recommended that I, the client, see a physician for any ailments I might have. Any suggestions made by the massage therapist are recommendations not prescriptions. My signature below indicates that I understand and agree to the above conditions:

Signature: _____ Date: _____