Peaceful Hills Massage and Wellness

Massage Intake Form

Name: _____ Date: _____

Phone (Cell): _____ Phone (Alternate): _____

Email Address: _____ Date of Birth: _____

Street Address: _____ City/State/Zip: _____

Occupation: _____ How did you hear about us? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Massage Experience

1) Have you received a professional massage or other bodywork previously? □ Yes □ No

If yes, what types of bodywork have you received? (Swedish, Deep Tissue, Acupuncture, Chiropractic, etc.)

_____

2) How long have you been receiving massage therapy? _____ *Frequency of massages?* _____

3) What are your goals for this treatment session?

□ Relaxation □ Injury Rehabilitation/Pain Relief □ Maintenance Massage □ Other: _____

4) On a scale of 1-5, what level of pressure do you prefer? (1 = very light, 5 = very deep) _____

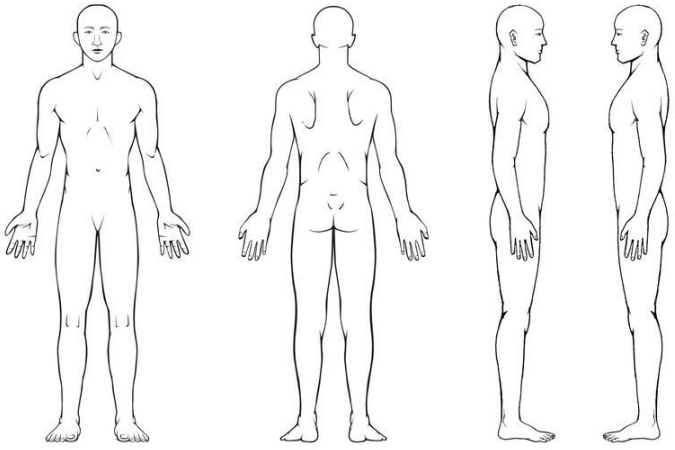
5) Do you have any difficulty lying on your front, back, or side? □ Yes □ No

If yes, please explain: _____

6) Do you have any music preferences? □ Yes □ No *If yes, please specify:* _____

7) Do you prefer talking or no talking? □ Talking is okay □ No talking please

8) Please circle any areas you want worked on and put an "X" where you don't want to be touched.



9) Is there any additional info you would like to add that may be helpful?

_____

_____

Health History

Primary Care Provider: _____ Phone: _____

If you are currently taking any medications, including OTCs and supplements, please list them below:

Medication/Supplement	***Reason for Taking***

Please check the box for all conditions that apply to you:

Musculoskeletal
- □ Tendonitis or Bursitis
- □ Arthritis or Lupus
- □ Gout
- □ Jaw Pain or TMJ
- □ Spinal Problems
- □ Headaches or Migraines
- □ Osteoporosis

Nervous System
- □ Numbness, Tingling, or Decreased Sensation
- □ Pinched Nerve
- □ Chronic Pain *(What helps? What makes it worse?)*
- □ Paralysis
- □ Multiple Sclerosis
- □ Parkinson's Disease
- □ Fibromyalgia
- □ Epilepsy or Seizures

Circulatory
- □ Heart Condition
- □ Previous Heart Attack or Stroke
- □ Atherosclerosis
- □ Varicose Veins or Phlebitis
- □ Blood Clots
- □ Thrombosis or Embolism
- □ High or Low Blood Pressure
- □ Lymphedema

Skin
- □ Contagious Skin Condition, Poison Ivy or Rash
- □ Open Sores or Wounds
- □ Athlete's Foot
- □ Herpes or Cold Sores
- □ Bruise Easily
- □ Sunburn
- □ Cosmetic Surgery

Digestive
- □ Irritable Bowel Syndrome
- □ Bladder or Kidney Ailment
- □ Colitis
- □ Crohn's Disease
- □ Ulcers

Respiratory
- □ Asthma or Breathing Difficulty
- □ Emphysema
- □ Sinus Problems

Reproductive
- □ Pregnant, stage: _____
- □ Ovarian or Menstrual Problems
- □ Prostate

Psychological
- □ Anxiety or Stress Syndrome
- □ Depression

Other
- □ Fever
- □ Swollen Glands
- □ Cancer or Tumors
- □ Diabetes
- □ Drug, Alcohol, or Tobacco Use
- □ Contact Lenses
- □ Dentures
- □ Hearing Aids

□ **Any surgeries, injuries, or accidents?** *(sprains, strains, broken bones, etc.) Please include dates if possible.*

_____
_____
_____
_____

□ **Any allergies or sensitivities?**

_____
_____
_____
_____

□ **Other condition(s) not listed:**

_____
_____
_____
_____

Explain any conditions you have marked above:

_____
_____
_____

By signing below, you agree that I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____