Therapeutic Massage Intake Form *Mei Leslie, LMT, CST-T*
Selah Massage & Bodywork

Client Information

Name _____ Date _____

Address _____ City, State & Zip _____

Phone_____(Circle: Cell / Home / Work) Email _____

I prefer to receive appointment reminders via: ❑ Text ❑ Phone call/Voice mail ❑ Email

Birthday_____/_____/_____ Occupation_____

Emergency Contact _____ Phone _____

Current Health Information

Are you generally in good health? ❑ Yes ❑ No Daily water intake: _____ 16 oz glasses

Women: Are you pregnant, post-delivery, or nursing? ❑ Yes ❑ No

Activity Level:

Exercise: ❑ regularly ❑ occasionally ❑ never

Sports/exercises/hobbies you do regularly: _____

Indicate consumption:

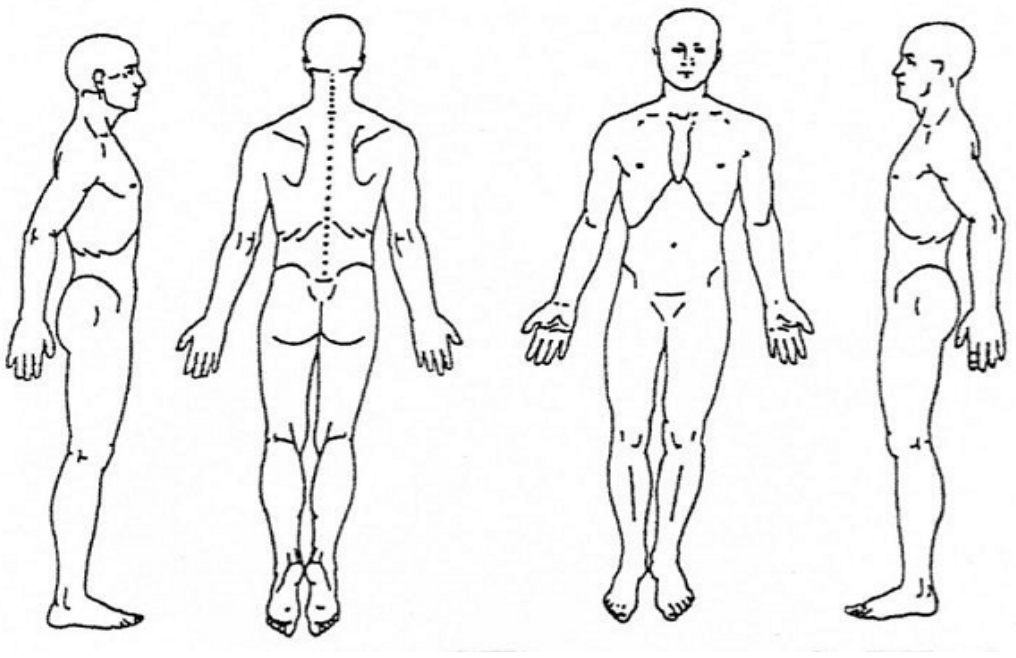
Caffeine	❑ None	❑ Light	❑ Moderate	❑ Heavy
Alcohol	❑ None	❑ Light	❑ Moderate	❑ Heavy
Nicotine	❑ None	❑ Light	❑ Moderate	❑ Heavy

How would you describe your overall level of stress? ❑ Low ❑ Medium ❑ High

Have you had previous professional massage / bodywork? ❑ Yes ❑ No

Are you currently in any pain? ❑ Yes ❑ No If yes, is it: ❑ Light ❑ Moderate ❑ Severe

On the figures below, please circle any area needing attention today:



What is your major complaint/condition you want to improve, i.e., what are your specific goals for today's treatment?

_____

_____

When did you first notice this condition? _____ **I**s it getting worse? ❑ Yes ❑ No

What activities or products improve this condition? _____

What activities or products aggravate this condition? _____

Does this condition interfere with: ❑ Sleep ❑ Work ❑ Daily routine

Indicate any that apply. I wear/have:

❑ Contact lenses	❑ Eyeglasses	❑ Orthotics	❑ Hearing aid
❑ Pacemaker	❑ Dental appliance	❑ Breast implants	❑ Hair piece / wig
❑ Allergies _____	❑ Undiagnosed lumps	❑ Port	❑ Other _____

Medications currently taking: Please list specific medications on a separate sheet of paper.

❑ antibiotics	❑ anti-coagulants	❑ anti-depressants	❑ anti-inflammatory
❑ anti-diuretic	❑ anti-stress	❑ beta blocker	❑ blood thinner
❑ bronchial dilator	❑ diuretic	❑ hormone replacement	❑ insulin
❑ muscle relaxant	❑ pain killers	❑ ulcer medication	❑ vitamins/supplements
❑ other _____			

Medical History *(Check any that apply)*

❑ arthritis	❑ coronary heart disease	❑ osteoporosis
❑ asthma	❑ congestive heart disease	❑ phlebitis
❑ cancer history	❑ angina	❑ PMS syndrome
❑ carpal tunnel syndrome	❑ stroke, TIA	❑ psoriasis / eczema
❑ chronic pain	❑ traumatic brain injury/TBI	❑ sciatica
❑ diabetes, type 1 / type 2	❑ high blood pressure	❑ scoliosis
❑ dizziness/vertigo	❑ HIV / AIDS	❑ skin conditions
❑ epilepsy	❑ infectious conditions	❑ sports injury
❑ fainting	❑ kidney ailments	❑ tendonitis
❑ fibromyalgia	❑ lung / respiratory ailments	❑ ticklish
❑ headaches	❑ lymphedema	❑ TMJ syndrome
❑ migraines	❑ multiple sclerosis	❑ tuberculosis
❑ GERD	❑ muscular dystrophy	❑ ulcers
❑ hepatitis	❑ neck/spine injury	❑ varicose veins

List any hospitalizations, surgeries, bone fractures, joint replacements, accidents you have had, or conditions not listed above:

_____

_____

Are you presently under the care of a physician/osteopath/naturopath, chiropractor, physical therapist,

psychotherapist or other health care practitioner? ❑ Yes ❑ No May I contact? ❑ Yes ❑ No

Name/Phone _____

Please read and sign:

I understand that massage therapy is for the purpose of stress reduction and/or relief from muscular tension/spasm; and that the therapist does not diagnose illness, disease, or any other physical or mental disorder, or prescribe medical treatment or perform spinal manipulations. Information exchanged during the session is educational in nature and intended to help me become more conscious of my own health status. I have reported all my existing medical conditions and agree to report any changes as they occur. I understand I have the right to refuse treatment at any time during the session. I consent to have therapeutic massage and do not hold the therapist liable for complications that may arise as a result of the massage.

Please note: If you have a specific medical condition or present specific symptoms, certain massage or bodywork techniques may be contraindicated. A referral from your Primary Care Provider may be required prior to your session. When no referral is provided the therapist reserves the right to refuse treatment.

Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(If client is under 18 years old)