

## Massage Therapy Intake Form »

\*\*It is the policy of Healthquest that payment be made at the time of service. Receipts are provided for the patient to arrange reimbursement from your extended insurance policy if applicable.

### Past Health History (please include description and date)

Surgeries/operations: \_\_\_\_\_

Accidents or falls: \_\_\_\_\_

Please check the appropriate box for any of the following conditions you now have. Please underline any of the following conditions you have had in the past.

#### Musculoskeletal

- Bone or joint diseases
- Tendonitis
- Bursitis
- Broken/fractured bones
- Arthritis
- Sprains/strains
- Low back, hip, leg pain
- Neck, shoulder, arm pain
- Headaches/head injuries
- Spasms/cramps
- Jaw pain/TMJ
- Flat feet/high arches
- Other:

#### Circulatory

- Heart condition
- Varicose veins
- Blood clots
- High blood pressure
- Low blood pressure
- Lymphedema
- Other:

#### Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Asthma
- Allergies
- Ear aches

#### Skin

- Dryness
- Bruise easily
- Allergies
- Rashes
- Athletes foot
- Warts
- Other:

#### Digestive

- Constipation
- Diarrhea
- Gas/bloating
- Diverticulitis
- Irritable bowel syndrome
- Other:

#### Nervous system

- Numbness/tingling
- Chronic pain
- Herpes/shingles
- Fatigue
- Sleep disorders
- Other:

#### Genito-urinary

- Pregnant (how many months)
- PMS
- Menopause
- Frequent urination
- Kidney infection
- Painful urination
- Prostate trouble
- Other:

#### Other

- Cancer/tumors
- Diabetes
- Mental health conditions
- Poor nutrition
- Drug/alcohol consumption
- Nicotine
- Caffeine
- Other:

#### Infectious diseases (name below)

Massage History/Treatment Information:

Have you received a professional massage? Yes No If yes, date of last massage: \_\_\_\_\_

What results do you want from your massage session? \_\_\_\_\_

\_\_\_\_\_

Current Concern: \_\_\_\_\_

Describe the onset: \_\_\_\_\_

Rate symptoms: Mild, Moderate, or Severe

Are you currently being treated by anyone else for your complaint? If Yes with who?

List medications, including aspirin, ibuprofen, antihistamines, birth control, etc.

\_\_\_\_\_  
\_\_\_\_\_

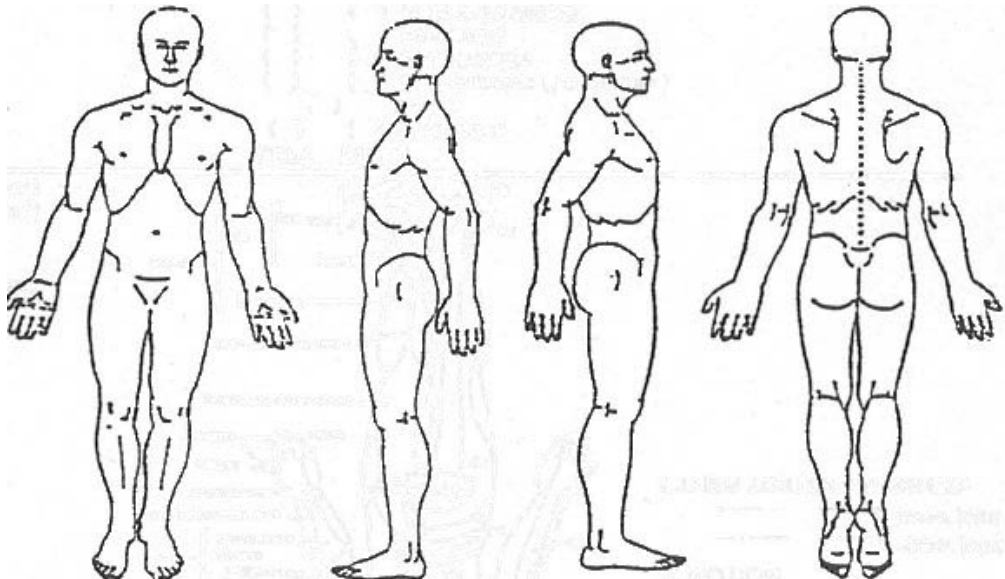
On the diagram please indicate areas where you are experiencing pain or unusual feeling.

Legend:

Pain = X

Numbness = O

Stiffness = //



**Please read the following:**

I understand that massage is given here for the purpose of; stress reduction, relief from muscular tension, spasm or pain, and the increase of circulation or energy flow.

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulation. It has been made clear to me that massage therapy is not a substitute for medical examination, diagnosis, or treatment and it is recommended that I see a Chiropractor or Medical Doctor for any physical ailment I might have.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_