Marianne Sears, LMP

MASSAGE INTAKE FORM

Name _____ Date _____

Address _____ Date of Birth _____

_____ Age _____

Home Phone _____

Work/Cell Phone _____

E-mail _____

Occupation _____

What is the main reason for this visit?

Have you received massage before?

Are you currently receiving any medical or chiropractic treatment?

Name of practitioner:

Please list any medications taken at regular intervals:

Do you currently (mark with a C) or have you in the past (mark with a P) experienced to a significant degree any of the following conditions?

___ allergies
___ athlete's foot
___ arthritis
___ back pain/problems
___ broken bones
___ bursitis
___ cancer
___ circulation problems
___ constipation
___ diarrhea
___ diabetes
___ digestive problems
___ drug/alcohol/caffeine abuse
___ epilepsy/seizures
___ headaches
___ heart attacks or ailments
___ hemophilia
___ herpes virus
___ high or low blood pressure
___ H.I.V. positive
___ insomnia
___ kidney/bladder ailment
___ menstrual problems
___ muscle spasms
___ osteoporosis
___ sciatica
___ stiff joints
___ skin problems
___ strains/sprains
___ excess stress/anxiety
___ tendonitis
___ tingling/numbness/nerve problems
___ thrombosis/embolism
___ varicose veins/phlebitis
___ whiplash

Please list major illnesses, surgeries or hospitalizations and any past injuries still affecting you.

See reverse side.

Are you currently experiencing any of the following conditions?

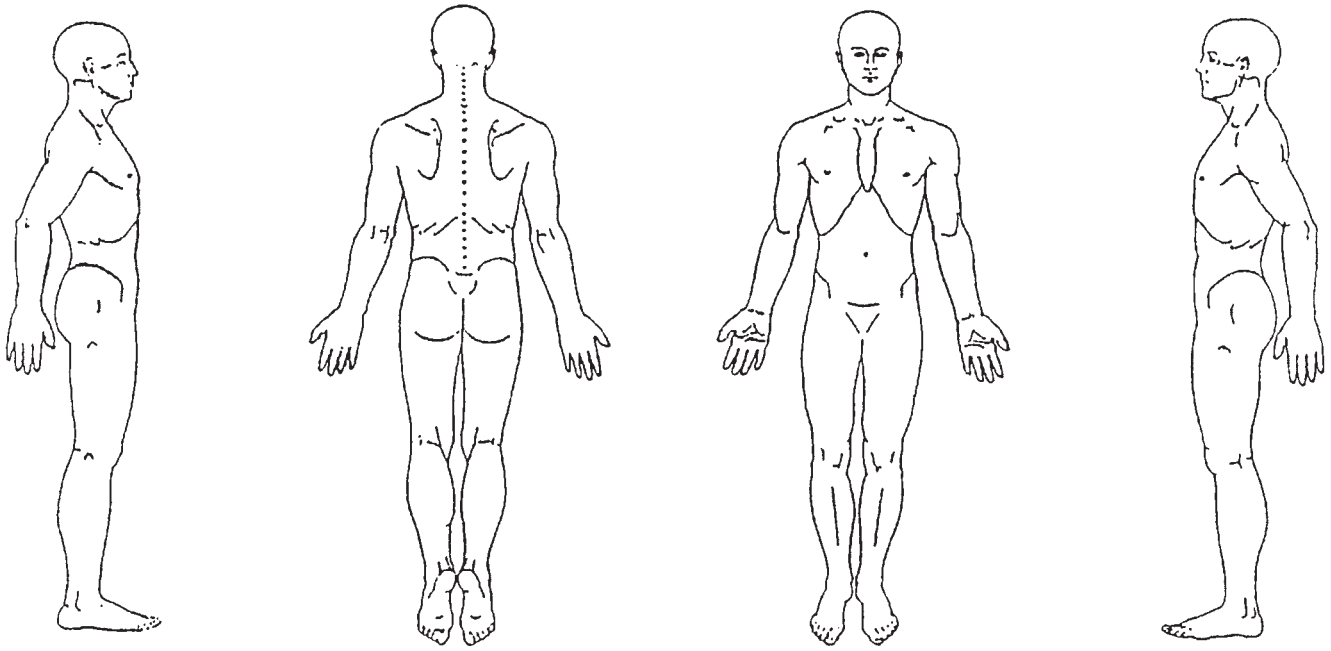
___ pregnancy
___ inflammation
___ fever
___ localized infection
___ wearing contact lenses
___ flu or cold
___ communicable illness

Are there any areas of your body that you have special sensitivities about or dislike having touched?

Any areas you especially like worked on?

Where do you tend to hold tension?

On the figures below, please indicate areas of pain or discomfort.



The above information is complete and accurate to the best of my knowledge. I agree to pay for my massages at the time of treatment unless other arrangements have been made. I understand that I may be charged for any appointment broken with less than 24 hours prior notice. I agree to the release of information for medical or insurance purposes. I authorize Marianne Sears, LMP, to obtain information from my primary health care providers concerning my health.

Signature _____ Date _____