Dorothy Frament, LMT Massage Therapist
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Massage Client Intake Form

Name:_____ **Date:** _____/_____/_____
Address:_____
City/State/Zip:_____**Occupation:**_____
Phone: (Home):_____ **Cell:**_____ **Work:**_____
Birthdate: _____/_____/_____ **Height:** _____ **Weight**_____ **Gender: M**____ **F**_____
Email Address:_____
Emergency Contact:_____ **Phone:**_____
Indicate by initialing below if you have consumed any intoxicating substance or non-prescribed drug prior to arriving for your bodywork session. Yes_____ **No**_____ **If yes, please indicate substance consumed:**_____

Have you ever received a professional massage ____ YES ____NO If yes, Frequency/type:_____
When was last massage?_____ **What results do you want from your massage?**_____
_____
Are you currently seeing a medical practitioner? Please explain if yes ____YES ____NO_____
_____
List current medications, including aspirin, ibuprofen, herbs, supplements, etc. _____
_____
List stress reduction and exercise activities (include frequency) _____
_____
MEDICAL HISTORY (Include year and treatment received)
Allergies: _____
Surgeries:_____
_____
Accidents/Injuries/Illnesses:_____
_____
_____
Are you wearing contacts?_____ **Dentures?**_____ **Transdermal patches**_____ **IV Port**_____
Do you have an open case with: Workers' Compensation? Yes__ No __ No-Fault? Yes__ No___

Having a complete medical history is important for the assessment process and for the determination of your customized massage plan. In each of the following sections, please mark the "past" and/or "current" box next to any of the items that apply to your health history.

MUSCULATOSKELETAL

Past	Current		Past	Current	
____	___	bone or jt. disease	____	____	low back, hip pain
____	____	tendonitis	_____	____	neck, shoulder, arm pain
____	____	bursitis	_____	_____	headaches
____	____	broken/fractured bones	_____	____	spasms/cramps
____	____	arthritis	_____	____	jaw pain
____	_____	sprains/strains	_____	____	lupus
____	____	scoliosis	_____	____	wrist/hand pain
____	____	disc disease/herniated disc	_____	____	leg/foot pain
____	____	Other (please explain):_____			

_____

CIRCULATORY
Past Current
_____ _____ **Heart Vessel condition**
_____ _____ **Varicose Veins**
_____ _____ **High Blood Pressure**
_____ _____ **Low Blood Pressure**
_____ _____ **Blood Clots**
_____ _____ **Lymphedema**
_____ _____ **Other_____**

URINARY
Past Current

_____ _____ **Cystitis**
_____ _____ **Kidney Disease**
_____ _____ **Urinary Tract Infection**
_____ _____**Other _____**

NERVOUS SYSTEM
Past Current

_____ _____ **Numbness/Tingling**
_____ _____ **Chronic Pain**
_____ _____ **Herpes/Shingles**
_____ _____**Fatigue**
_____ _____ **Sleep Disorders**
_____ _____ **Other_____**

DIGESTIVE
Past Current
_____ _____ **Chronic Problematic Constipation**
_____ _____ **Crohn's Disease**
_____ _____ **Diverticulitis**
_____ _____**Irritible Bowel Syndrome/Colitis**
_____ _____ **Reflux**
_____ _____ **Other_____**

RESPIRATORY
Past Current
_____ _____ **Breathing Difficulty**
_____ _____ **Sinus Problems**
_____ _____ **Allergies**
_____ _____ **Other _____**

REPRODUCTIVE
Past Current
_____ _____ **Pregnancy, # wks_____**
_____ _____ **Endometriosis**
_____ _____ **Menopausal Symptoms**
_____ _____ **Painful Irregular Periods**
_____ _____ **Other_____**

SKIN
Past Current
_____ _____ **Rashes/eczema/psoriasis**
_____ _____ **Athlete's Food**
_____ _____ **Warts**
_____ _____ **Allergies**
_____ _____ **Other _____**

OTHER
Past Current
_____ _____**Headaches/Migraines**
_____ _____ **Cancer/Tumors**
_____ _____**Thyroid Issues**
_____ _____**Diabetes**
_____ _____ **Eating Disorders**
_____ _____**Depression/Anxiety**
_____ _____ **Drug/Alcohol/Nicotine Addiction**
_____ _____ **Hearing Loss**
_____ _____**Other_____**

It is my choice to receive massage therapy. I understand that massage is for well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, and for increasing circulation and energy flow. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I understand that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update my practitioner of any changes in my health status. I agree to communicate with my practitioner at any time I feel my well-being is being compromised.

***** I am aware that session time has been reserved for me. If I am unable to make an appointment, I agree to give 24 hrs notice in order to avoid paying the session fee of $80/hr for same day cancellation or missed appointment.***

_____ _____
SIGNATURE **DATE**