



Diana Remaley Massage Therapy

Client Intake Form

Name: _____ Date: _____

Address (Street, city, state): _____

Phone: _____ Date of Birth: _____

Email: _____

Occupation: _____

Posture assumed most of the day (standing/seated/etc.): _____

Are you presently experiencing any pain or discomfort? _____

Have you previously received a professional massage? _____

(Describe any relevant details) _____

How did you hear about this office? (Website, referral, etc.) _____

Habits:

Exercise _____

Tobacco _____ Alcohol _____ Caffeine _____

Sleep _____ Drugs (non-prescription) _____

Do you experience any difficulty lying on your back or stomach? _____

Have you consumed any narcotics in the past 24 hours? _____

Are you currently taking any prescription medication? _____

Please list: _____

Please describe the condition for which it was prescribed: _____

Medical History

Please indicate if you are presently experiencing or have experienced any of the following conditions:

_____ Skin condition (acne, rash, psoriasis, allergies, warts, Botox, other) _____

_____ Allergies: Please specifically list _____

_____ Diabetes

_____ High or low blood pressure

_____ Asthma

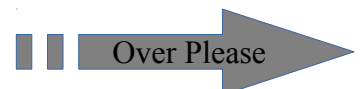
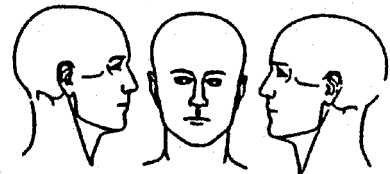
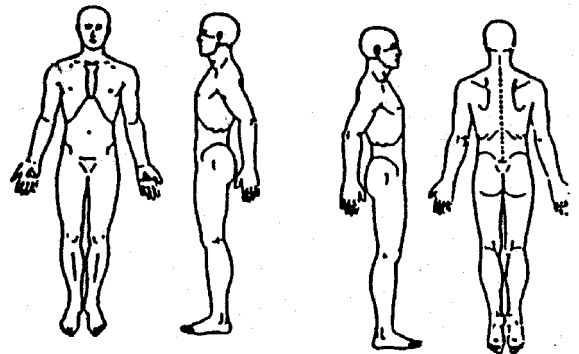
_____ Cancer (Please list type and date) _____

_____ Thyroid condition (please specify) _____

_____ Lymphatic condition (swollen glands, lymphedema, lymphoma, etc.)

_____ Recent injury or accident (whiplash, sprain, strain, etc.)

Please mark any area where you are experiencing pain or discomfort



- _____ Circulatory Condition (heart disease, varicose veins, phlebitis, arrhythmia, atherosclerosis, etc.)
- _____ Neurological Condition (sciatica, numbness/tingling, stroke, epilepsy, etc.)
- _____ Joint problems, pain, stiffness, (arthritis, gout, hypermobility, etc.)
- _____ Bone condition (previous fracture, cancer, etc.)
- _____ Headaches (migraines, tension, PMS, cluster, sinus, etc.)
- _____ Emotional difficulties (depression, anxiety, etc.)
- _____ Stress
- _____ Digestive disorders (Crohn's disease, IBS, constipation, etc.)
- _____ Previous surgery (please list type and date) _____
- _____ Any other medical condition (please specify) _____
- _____ Are you pregnant?

Primary Health Care Provider: _____

PCP Address: _____

PCP Phone: _____

Permission to Contact PCP? If yes, please initial _____

Emergency Contact Name/Relationship: _____

Emergency Contact Phone: _____

Agreements and Acknowledgments

Client understands that massage therapy provided is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Health Care Provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

Client understands that there are remote risks associated with massage therapy. Client acknowledges that massage therapist is not liable for any injury resulting from unreported conditions and/or concerns.

Client acknowledges that massage therapy performed is strictly non-sexual and that proper draping techniques will be observed at all times. Client also acknowledges that appropriate hygiene will be maintained at all times in office.

Client has informed the massage therapist of all my known physical conditions, medical conditions and medications, and will keep the massage therapist updated on any changes.

I have read and understand this document.

Client
Signature _____ Date _____