Massage Therapy Intake | Shevone DiSanti, RMT

Today's Date: / /

Name:

Address:

City: **State:** **Zip:**

Date of Birth: / /

Age: **Weight:** lbs

Marital Status: **Height:** ' "

Occupation:

Email address:

Cell Phone:

How did you hear about us?

Emergency Contact... **Name:** **Number:**

May we contact you by... ☐ **Phone?** ☐ **Email?** ☐ **Voicemail?**

Clinic Use Only

Notes:

HEALTH HISTORY

Please list any allergies:

Have you had a professional massage before? ☐ Yes ☐ No

If yes, how often do you receive massage therapy?

Do you sit for long periods of time at a computer/driving? ☐ Yes ☐ No

If yes, please indicate

Do you perform any repetitive movement in work, sport or hobby? ☐ Yes ☐ No

If yes, please explain

Do you experience stress often in your life?

☐ Anxiety ☐ Insomnia ☐ Irritability ☐ Muscle Tension

☐ Other:

Please identify particular areas of the body you are experiencing tension, stiffness, pain/discomfort:

What are your goals/intentions for this massage session?

Do you do any form of regular cardio exercise or strength training? ☐ Yes ☐ No

If yes, please indicate

Do you practice yoga, meditation or other forms of internal arts? ☐ Yes ☐ No

If yes, what is most helpful to your well being?

Please list other therapies you currently receive:

PERSONAL MEDICAL HISTORY

Do you have any of the following today?

☐ Cold or flu Pregnant - Due Date: / /

☐ Open cuts/sores Skin rash - Where?

Have you ever had/do you have any of the following:

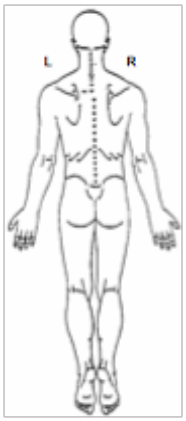
☐ AIDS/HIV ☐ Blood clots ☐ Cancer ☐ Constipation

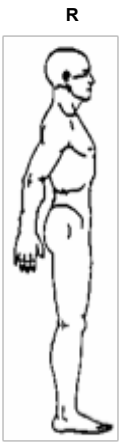
☐ Diabetes ☐ Epilepsy/Seizure ☐ Heart attack/MI ☐ High blood pressure

☐ Kidney disease ☐ Liver disease ☐ Low blood pressure ☐ Neuropathy/numbness

☐ Other:

Please mark your conditions, areas of concern and/or pain.





PERSONAL MEDICAL HISTORY CONTINUED

Are you currently under medical/therapeutic treatment? ☐ Yes ☐ No

If yes, please explain _____

Please list any medications you may be taking:

_____

_____

Please list any surgeries you have had:

_____

If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I consent for massage therapy performed by Shevone DiSanti RMT.

Signature: **Date:**

Clinic Use Only

Notes: