# Patient Intake Form – Please complete before your therapist arrives



First Name _____ Date of birth _____

Last Name _____ Referred by _____

Email Address _____ Mobile Phone # _____

Home Phone # _____ Work Phone # _____

Street Address _____ City _____

State _____ Zip Code _____

Emergency contact name _____ Physician's name _____

Emergency contact relationship _____ Physician's phone # _____

Emergency phone # _____

Date of initial visit _____

How would you rate your general health?

◯ Excellent ◯ Good

◯ Fair ◯ Poor

Have you had a professional massage before?

◯ Yes *(Date of last treatment)* _____

◯ No

List current medications & the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

Reason for initial visit

**HEAD NECK**

- ◯ Headaches / migraines
- ◯ Vertigo / dizziness
- ◯ Ringing in ears
- ◯ Hearing loss
- ◯ Vision problems
- ◯ Vision loss

**RESPIRATORY**

- ◯ Asthma
- ◯ Shortness of breath
- ◯ Chronic cough
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Sinusitis
- ◯ Frequent colds
- ◯ Smoker
- ◯ Family history of respiratory difficulties

**NERVOUS SYSTEM**

- ◯ Sensory loss / change
- ◯ Numbness / tingling
- ◯ Sciatica
- ◯ Epilepsy
- ◯ Seizures
- ◯ Multiple sclerosis

**MUSCULOSKELETAL SYSTEM**

- ◯ Arthritis
- ◯ Family history of arthritis
- ◯ Osteoporosis
- ◯ Tendonitis
- ◯ Bursitis
- ◯ Jaw pain (TMJ)
- ◯ Pins / plates / wires / artificial joint

**REPRODUCTIVE**

- ◯ Pregnant
- ◯ Given birth
- ◯ Gynecological problems

**CARDIOVASCULAR**

- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Heart attack
- ◯ Stroke
- ◯ Heart disease
- ◯ Poor circulation
- ◯ Phlebitis / varicose veins
- ◯ Pacemaker
- ◯ Hemophilia
- ◯ Chronic congestive heart failure
- ◯ Family history of cardiovascular problems

**SKIN & INFECTIONS**

- ◯ Hepatitis
- ◯ HIV / AIDS
- ◯ Herpes
- ◯ Tuberculosis
- ◯ Lyme disease
- ◯ Infectious skin conditions

**OTHER CONDITIONS**

- ◯ Cancer
- ◯ Diabetes
- ◯ Unexplained weight loss
- ◯ Digestive conditions
- ◯ Fibromyalgia
- ◯ Chronic fatigue syndrome
- ◯ Depression
- ◯ Anxiety
- ◯ Psychiatric disorder
- ◯ Other conditions _____

_____

_____

_____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature: _____ Date: _____

# Coronavirus (COVID-19) Precautions:

**For your health and safety:**

- Please use wash your hands or use hand sanitizer upon arrival of your therapist
- All equipment and linens are cleaned and sanitized before arrival
- Both client and therapist will have temperature checked
- Therapist health is monitored closely

**Please acknowledge the above statements and answer the questions below:**

1. Have you been sick with cold/flu symptoms or have had a fever in the last 30 days?

   YES NO

2. Have you been exposed to anyone who is or has been sick with these symptoms?

   YES NO

3. Have you traveled outside of the US in the last 30 days?

   YES NO

4. Has anyone you have been in close contact with traveled outside of the US within the last 30 days?

   YES NO

Patient Name: _____ Date: _____

Patient Signature: _____

Patient Temperature: _____

Therapist Temperature: _____