Express Your Health

Massage Patient Intake Information

Name____Age________________Date of Birth______________________

Address____City/State/Zip____

Phone____________________________Cell Phone________________________Email___________________________________

Occupation_____________________________Employed by______________________Work Phone_______________________

Insurance Company_____________________________________Social Security #_______________________________________

Referred By____

Have you ever had a Massage or Bodywork session?_______________________How recently?____________________________

Have you had chiropractic care before?__________________________________How recently?____________________________

If you have a specific medical condition or specific symptoms, massage/bodywork maybe contraindicated. Please check any of the following symptoms which you may now have or have had previously. ***THIS IS A CONFIDENTIAL HEALTH REPORT.***

Do you have diabetes?
☐Yes ☐No

Are you pregnant?
☐Yes ☐No

Do you suffer from arthritis?
☐Yes ☐No

Do you suffer from joint swelling?
☐Yes ☐No

Do you have high blood pressure?
☐Yes ☐No

If yes, what blood pressure medication?

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Do you have cardiac or circulatory problems?
☐Yes ☐No

Do you suffer from epilepsy or seizures?
☐Yes ☐No

Have you had surgery in the last 2 yrs?
☐Yes ☐No

Do you have osteoporosis?
☐Yes ☐No

Do you bruise easily?
☐Yes ☐No

Any broken bones in the past 2 yrs?
☐Yes ☐No

Have you been in an accident or suffered from any injuries in last 2 yrs? ☐Yes ☐No

Do you or have you had any form of cancer?
☐Yes ☐No

Do you suffer frequently from stress?
☐Yes ☐No

Do you experience frequent headaches?
☐Yes ☐No

Do you have tension or soreness in a specific area?
☐Yes ☐No

Do you suffer from back pain?
☐Yes ☐No

Do you suffer from numbness or stabbing pain?
☐Yes ☐No

Are you sensitive to touch or pressure in any area?
☐Yes ☐No

Do you have any contagious disease?
☐Yes ☐No

Do you have any other medical condition that your therapist should be aware of?
☐Yes ☐No

Do you have any allergies?
☐Yes ☐No

Do you have any sensitivity to fragrances?
☐Yes ☐No

Comments ___________________________________

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Cancellation Policy: For a massage therapy appointment that is cancelled with less than a 24-hour notice, half of the session fee will be charged. This fee is not billable to insurance.

Please take a moment to carefully read the following information and sign where indicated.

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork 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. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so. It is also understood that any illicit or sexually suggested remarks or advances will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client signature:____Date___________________________

Therapist signature:____Date:__________________________