momentum
SPORTSTHERAPY

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Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip_____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Relation _____ Phone _____

How did you hear about us?_____

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? _____

2. List your exercise activities & frequency: _____

_____

3. Are you currently taking any prescribed medications or vitamins/supplements? Yes No

If yes, please explain: _____

4. List any accidents or injuries you have been in: _____

5. List any surgeries (and year): _____

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe: _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe: _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think it has affected your health??

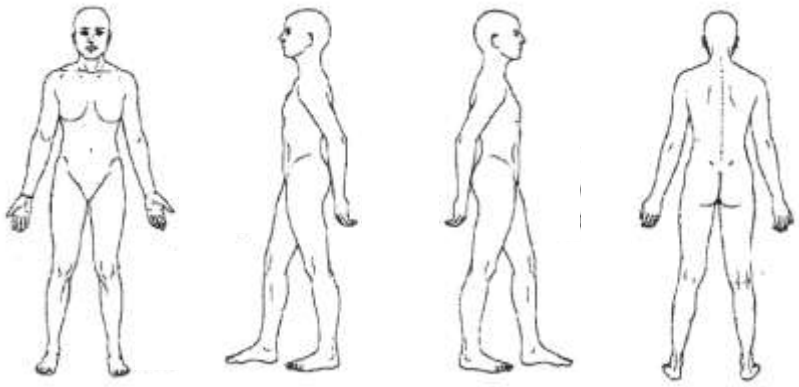
muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____

9. Are you currently under the care of a physician, chiropractor or physical therapist? Yes No

If yes, what are you treated for? _____

Circle any specific areas you currently experience pain or discomfort, using the key below to describe:

P = Pain or Tenderness
S = Joint/Muscle Stiffness
N = Numbness/Tingling



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Medical History

In order to plan a massage session that is safe and effective,
I need some general information about your medical history.

10. Describe the areas of any chronic tension you experience. _____

What aggravates it? _____

What alleviates it? _____

11. How many hours of sleep do you receive each night? _____

12. Daily intake Water _____

Caffeine _____

Alcohol _____

Please check any of the following that apply to you in the past or present:

Condition	Past	Present	Condition	Past	Present
Headaches *Type:*			Pins & Needles in Arms, Legs, Hands, or Feet		
Asthma			Neurological Problems		
Cold Hands/Feet			Spinal Problems		
Swollen Ankles			Herniated/Bulging Discs		
Sinus Conditions			Osteoarthritis		
Frequent Colds			Arthritis		
Allergies (specify below)			Anxiety		
Loss of smell/taste			Depression/Panic		
Skin Conditions			Sleep Disturbance		
Painful/Swollen Joints			Loss of Memory		
Auto-Immune Disorder			Whiplash		
Cancer			Bruises Easily		
Varicose Veins			Constipation/Diarrhea		
Blood Clots/DVT			Contact Lenses		
Heart Problems			Dentures/Partials		
Pacemaker			Hemorrhoids		
High/Low Blood Pressure			Artificial/Missing Limbs		
Diabetes			Muscular Tension		
Epilepsy or Seizures			Sciatica		
Fainting Spells			Pregnancy (if current, months?)		

Further explanation of any condition or other information: _____

_____

15. Is there anything else about your health history that would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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.

Signature of Patient _____ Date_____

Signature of Massage Therapist _____ Date _____