Massage Intake Form

Address 14.512 New 11 Huy City/State/Zip Cologio DOB OT Ot Q 7	Personal Information		
Address 16412 Name How City/State/Zip Cologo	Name Alison Thou	e S Phon	e (day) (evening)
Employer	Address 14912 News	Il they city/s	itate/Zip Colgero. DOB 07/oc/a7
Email	Occupation Vet		Employer
Emergency Contact Medical Information	Email alison. thous	s 365@ quail-con	્રત્ _પ Primary Physician
Medical Information Are you taking any medications? yes no If yes, please list name and use: What type of massage are you seeking? Relaxation Therapeutic/Deep Tissue Other What type of massage are you seeking? Relaxation Therapeutic/Deep Tissue Other What pressure do you prefer? Uight Medium Deep Do you suffer from chronic pain? yes no If yes, please explain What makes it better? Are there any areas (feet, face, abdomen, etc.) you do not want massaged? yes no Please explain What are your goals for this treatment session? What are your goals for this treatment session? Please indicate any of the following that apply to you. Please indicate any of the following that apply to you. Gancer Fibromyalgia Hadadaches/Migraines Stroke Arthritis Heart Attack Diabetes Kidney Dysfunction Joint Replacement(s) Blood Clots High/Low Blood Pressure Numbness Neuropathy Sprains or Strains By signing below you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. Date \$\frac{5}{7} \frac{7}{2} \frac{1}{2} \f			
Are you taking any medications?	How did you hear about us?	Google	
Are you taking any medications?	Medical Information		Massage Information
What type of massage are you seeking? Relaxation Therapeutic/Deep Tissue			
Are you currently pregnant? yes no			
Are you currently pregnant?			
What pressure do you prefer? Light Medium Deep	Are you currently pregnant?		
Light Medium Deep			
Do you suffer from chronic pain?			
Please explain Please explain Please explain Are there any areas (feet, face, abdomen, etc.) you do not want massaged? yes no Please explain What makes it worse? What makes it worse? What are your goals for this treatment session? What are your goals for this treatment session? What are your goals for this treatment session? Please indicate any of the following that apply to you. Cancer Fibromyalgia Headaches/Migraines Stroke Arthritis Heart Attack Diabetes Kidney Dysfunction Joint Replacement(s) Blood Clots High/Low Blood Pressure Numbness Neuropathy Sprains or Strains By signing below you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. Client Signature Date \$\frac{1}{2} \frac{1}{2}			
What makes it better? What makes it worse? What are your goals for this treatment session? What are your goals for this treatment session? Please circle any areas of discomfort Please circle any areas of discomfort Please circle any areas of discomfort What are your goals for this treatment session? What are your goals for this treatment session? Please circle any areas of discomfort			
What makes it worse? What makes it worse? What are your goals for this treatment session? Please circle any areas of discomfort Please circle any a			
What makes it worse? Have you had any orthopedic injuries? yes no If yes, please list: Please indicate any of the following that apply to you. Cancer	vinal makes it better?		
What are your goals for this treatment session: Have you had any orthopedic injuries? yes no If yes, please list: Please indicate any of the following that apply to you. Cancer	What makes it werse?		Please explain
Have you had any orthopedic injuries?	what makes it worser		
Please list: Please list: Please indicate any of the following that apply to you. Cancer	University band and address distance	iuriaa? 🗆 uaa 🗺	Love buch lelcane & reloxator
Please indicate any of the following that apply to you. Cancer			Please circle any areas of discomfort
Cancer Fibromyalgia Headaches/Migraines Stroke Arthritis Heart Attack Diabetes Kidney Dysfunction Joint Replacement(s) Blood Clots High/Low Blood Pressure Numbness Sprains or Strains Explain any conditions you have marked above: Wave completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. Client Signature Date Date			
Headaches/Migraines	Please indicate any of the following that apply to you.		
Headaches/Migraines	☐ Cancer	☐ Fibromvalgia	
Arthritis			
☐ Joint Replacement(s) ☐ Blood Clots ☐ High/Low Blood Pressure ☐ Numbness ☐ Neuropathy ☐ Sprains or Strains By signing below you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. Client Signature ☐ Date 5/7/14			W O T D
High/Low Blood Pressure Numbness Neuropathy Sprains or Strains Sprains or Strains	☐ Diabetes	☐ Kidney Dysfunction	
Explain any conditions you have marked above: We will be a signing below you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. Client Signature	☐ Joint Replacement(s)	☐ Blood Clots	
Explain any conditions you have marked above: Have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. Client Signature	☐ High/Low Blood Pressure	□ Numbness	1 \/ \\\(\)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
Explain any conditions you have marked above: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. Client Signature Date S 7 124	☐ Neuropathy	☐ Sprains or Strains	
knowledge and agree to inform my therapist if any of the above information changes at any time. Client Signature Date 5/7/24	Evoluin any conditions you have marked above.		
information changes at any time. Client Signature Date 5/7/24	Explain any conditions you if	ave marked above.	
		NA.	
			5/7/16
Therapist Signature Date 5/7/2	Miles and the second		Client Signature Date Date
			Therapist Signature Date 5/7/2 \footnote{2}