TRINITY WELLNESS CENTER
MASSAGE THERAPY INTAKE FORM

Name _____ DOB _____Age_____

Address _____

City & State_____Zip _____

E-Mail_____

Phone # you would like to be contacted at _____

Is it OK to leave messages regarding appointments? Yes No

Primary Physician _____

Address & Phone # _____

Emergency Contact

Name_____Phone #_____

Relationship_____

DO YOU HAVE ANY ALLERGIES TO NUTS, OILS, PERFUMES OR HERBS?

Please list any over the counter and prescribed medications AND WHAT YOU TAKE IT FOR

Have you ever had a professional massage before? Yes No

Do you have difficulty lying on your back, front, or side? Yes No

If yes please explain _____

What type of work do you do?_____

Do you perform any repetitive movement for work, sports, or hobby? Yes (please explain) No

Please circle on a scale of 0-10, what would you rate your level of stress? 0 1 2 3 4 5 6 7 8 9 10

Would you say this stress causes; muscle tension anxiety insomnia irritability other

Please list any type of **surgeries** or **injuries with dates** or any **chronic musculoskeletal or nerve related** conditions.

Have you ever had chemotherapy or radiation therapy? Yes No (if No continue to For Women)

Diagnosis: Date of Diagnosis

Are you in treatment now?

Please list any Surgery related to this diagnosis: Date: Procedure:

Were lymph nodes removed? Location

If chemotherapy, Date started: Date of last session:

If radiation, Date started: Date of last session:

# of treatments: Radiation site:

Were lymph nodes radiated?

Do you currently have a medical device in place? Yes No

Describe any concerns related to your diagnosis and treatment that could affect your massage.

Do you have any medical restrictions regarding exercise?

Do you know your most recent platelet count? White blood cell count

For Women

Are you pregnant or trying to get pregnant? Yes No If preg. How many mos. _____

Are your menses usually regular irregular heavy light painful clotting

Please check the following as they apply to you.

Musculoskeletal	**Circulatory**	**Respiratory**	**Nervous Syst.**
Arthritis/Gout	Heart Condition	Asthma	Shingles
Tendonitis or bursitis	Phlebitis	Emphysema/COPD	Numbness/Tingling
Jaw Pain (TMJ)	High/Low B/P	Sinus Problems	Pinched Nerve
Spinal Problems	Blood Clots	Allergies, specify	Chronic Pain
Migraines/Headaches	Lymph edema	_____	Multiple Sclerosis

Skin	**Digestive**	**Psychological**	**Other**
Allergies, specify:	IBS	Anxiety/stress	Cancer/Tumors
_____	Crohn's Disease	Post Traumatic Stress	Diabetes
Rashes	Ulcers	Depression	Surgical hardware/implants
Herpes/Cold sores	Bladder/Kidney		_____

Do you wear contacts, hearing aid, dentures, IUD?

Do you have a pacemaker, access port, colostomy prosthetic, other?

Any other medical condition(s) not listed:

What is the main goal you have for your massage today?_____

Massage Therapists do not diagnose and treat any suspected medical problem. If you have a suspected health issue you should consult a Medical Doctor. Your Massage Therapist may refer you to an appropriate professional for care beyond their scope of practice**. I acknowledge that massage is not a substitute for medical exam or diagnosis. I have informed my massage therapist of any medical limitations or restrictions. I have stated all medical conditions of which I am aware, including communicable diseases and will update the therapist of any medical changes that occur in the future. I will promptly inform my massage therapist of any issues that arise during the massage**

Signature_____Date_____

Therapist Signature _____Date_____