Longboat Massage

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Est. Lic. # MM12915 MA #12474

Intake Form **Date_____**

PATIENT INFORMATION

Name: Last:_____First:._____MI____Nickname:_____

Address: _____

City:_____State:_____Zip:_____

Phone: HM (_____)_____Cell: (_____)_____

Summer Address: _____

City:_____State:_____Zip:_____

Email Address: (PLEASE PRINT):_____

Sex: ≤ M ≤ F Age: _____ Date of Birth:_____

Who Referred You? ≤ Doctor: _____≤ Patient: _____

≤ Internet ≤ Sign ≤ Other _____

PRESENT HISTORY:

Please rate your current stress level (1 – 10) _____

What is your primary complaint?_____

_____

Other areas of pain or concern?_____

_____

When did you first notice your primary complaint? ≤ Days____≤ Weeks____ ≤ Months____≤ Years____

What brought it on? _____

What activities aggravate your condition? _____

Is this condition interfering with: ≤ Work ≤ Sleep ≤ Daily Routine

Are you ≤ Right ≤ Left Handed

Do you have any allergies to oils or lotions?

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

_____

Do any of the following give you relief? ≤ Hot pack ≤ Cold pack ≤ Pain medication ≤ Rest ≤ Creams and lotions ≤ Other

Has there been a medical diagnosis? ≤ Yes ≤ No **If yes, what was the diagnosis?** _____

By whom? _____

X-rays: ≤ Yes ≤ No **Date**_____ **Blood Work** ≤ Yes ≤ No **Date**_____

MEDICATIONS:

Are you presently taking any medication(s)? ≤ Yes ≤ No **If yes, please identify below:**

Name of Medication	Dose (Milligrams)	Frequency (times/day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken any of the following in the last eight weeks?

≤ Laxatives ≤ Sedatives ≤ Sleeping pills ≤ Aspirins ≤ Vitamins
≤ Insulin ≤ Minerals ≤ Herbs ≤ Pain Medications

INTAKE:	Heavy	Moderate	Light	None
Alcohol	≤	≤	≤	≤
Coffee	≤	≤	≤	≤
Tea	≤	≤	≤	≤
Tobacco	≤	≤	≤	≤
Exercise	≤	≤	≤	≤
Soda	≤	≤	≤	≤
Water	≤	≤	≤	≤
Weekly sugar	≤	≤	≤	≤

PAST HISTORY:

Have you had a similar problem before? ≤ Yes ≤ No **If yes, when?**_____

What caused those episodes? _____

Have you ever had any operations? ≤ Yes ≤ No **If yes, describe briefly and give year?**_____

_____

Have you ever had any broken bones? ≤ Yes ≤ No **If yes, what area** _____**Date**_____

Have you ever been in an automobile accident? ≤ Yes ≤ No **Date**_____

Do you use a: ≤ **Foam pillow** ≤ **Feather pillow** ≤ **Orthopedic pillow**

Are you wearing: ≤ **Heel lifts** ≤ **Sole lifts** ≤ **Arch supports** **Do you bruise easily?** ≤ **Yes** ≤ **No**

DO YOU HAVE ANY DIFFICULITY WITH THE FOLLOWING: (Check only those that apply)

- ≤ Headaches
- ≤ Pains in Head/Face
- ≤ Twitching of face
- ≤ Head feels too heavy
- ≤ Sinus trouble
- ≤ Hay fever/Allergies
- ≤ Dizziness
- ≤ Fainting
- ≤ Ringing in ears
- ≤ Wear glasses
- ≤ Light bothers eyes
- ≤ Inflamed throat
- ≤ Tightness in throat
- ≤ Tightness of shoulder muscles
- ≤ Grating in neck
- ≤ High Blood Pressure
- ≤ Low Blood Pressure
- ≤ Disk degeneration
- ≤ "Pinched" nerve
- ≤ Sacroiliac or low back pain
- ≤ Pins & Needles in arms/legs
- ≤ Pain in arms & hands
- ≤ Skin Allergies
- ≤ Bruise easily
- ≤ Phlebitis
- ≤ Thrombosis
- ≤ Blood Clotting
- ≤ Indigestion
- ≤ Nervous stomach
- ≤ Stomach trouble
- ≤ Intestinal gas
- ≤ Ulcers
- ≤ Inner tension
- ≤ Irritability
- ≤ Sleeping problems
- ≤ Tire easily/lack of energy
- ≤ Fatigue
- ≤ Depression
- ≤ Muscle Spasms
- ≤ Arthritis
- ≤ Swollen joints
- ≤ Cold Sweats
- ≤ Chest Pain
- ≤ Heart palpitations
- ≤ Shortness of breath
- ≤ Asthma
- ≤ Heart attacks/strokes
- ≤ Loss of memory
- ≤ Loss of smell
- ≤ Loss of taste
- ≤ Liver trouble
- ≤ Gall Bladder Trouble
- ≤ Kidney trouble
- ≤ Bladder trouble
- ≤ Thyroid trouble
- ≤ Cancer
- ≤ Diabetes
- ≤ Anemia
- ≤ Other_____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

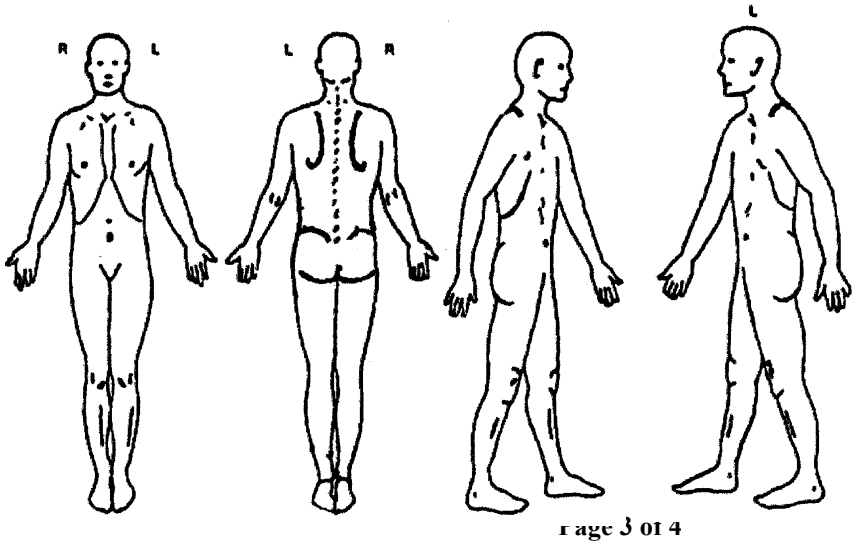
MALE: (Check Only Those That Apply)

- ≤ History of prostrate trouble
- ≤ Urination difficult or dribbling
- ≤ Frequent night urination
- ≤ Persistent abdominal pain
- ≤ Pain on inside of legs or heels
- ≤ Pain in groin area

FEMALE: (Check only those that apply)

- ≤ Premenstrual tension or depression
- ≤ Painful menstruation/cramps
- ≤ Menstruation excessive or prolonged
- ≤ Menstruation scanty or missing
- ≤ Vaginal discharge
- ≤ Painful breasts
- ≤ Menopausal hot flashes, etc.
- ≤ Birth Control Pills
- ≤ How many pregnancies? _____
- ≤ Pregnant: _____ months ____weeks
- ≤ Suspect I may be pregnant

MARK (SHADE IN) THE BODIES BELOW TO INDICATE WHERE YOUR PAIN IS:



Draping will be used during the session — only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age at 17.

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 skeleton 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 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 client_____ Date_____

Signature of Massage Therapist _____Date_____