Massage 101 Client Intake Form

date:_____

Name: First _____ Middle _____ Last _____

Address: _____

City, State, Zip: _____ Ph: _____

Date of Birth: _____ E-Mail: _____

Occupation: _____ Employer: _____

Referred By: _____

Massage Information

First Professional Massage: ___yes ___ no If NO, how often do you receive massages? _____

What is your goal for today's Massage Session? _____

Pregnant? ___yes ___ no If YES, which trimester? ___1st ___2nd ___3rd

(Note: For your protection, massage cannot be performed on anyone in her 1st trimester)

Medical Information

Please list **Accidents/Injuries**, **Hospitalizations** and **Surgeries**: When they occurred and treatment received

_____

_____

_____

Any Lingering effects from the above, or do you feel you have recovered?

_____

_____

Chronic, ongoing pain? ___no ___ yes, Please describe any care or treatment you receive:

_____

_____

Do activities affect the pain? ___no ___ yes, Please describe:

_____

_____

Are you being treated medically or taking prescription drugs? ___no ___ yes, Please describe:

_____

_____

Please list **ALL** over the counter drugs, supplements, and/or herbs taken and why:

_____

_____

_____

please continue form on other side!

Medical History *(to help determine treatment options)*

Musculoskeletal
__ Scoliosis
__ Osteoporosis
__ Arthritis
__ Hypothyroidism
__ Fibromyalgia
__ Chronic Fatigue
__ Gout In _____
__ Bursitis
__ Plantar Fasciitis
__ Cysts / Lipomas
__ TMJ
__ Chronic headaches
__ Tendonitis
__ Whiplash
__ Strains / Sprains
__ Chronic Pain in:
  __ Neck
  __ Low-back
  __ Mid-back
  __ Upper-back
  __ Hip
  __ Arm
  __ Leg
  __ Shoulder
  __ Wrist / Hand

Digestive
__ Ulcers
__ Colitis
__ IBS
__ Crohn's Disease
__ Gluten Intolerance
__ Constipation
__ Diarrhea
__ Gallstones
__ Kidney Stones
__ Gas / Bloating
__ Chronic Indigestion

Circulatory
__ Heart Problems
_____
__ Stroke
__ Palpitations
__ Mitral Valve Prolapsed
__ Anemia
__ Hemophilia
__ High Blood Pressure
__ Low Blood Pressure
__ Peripheral Artery Disease
__ Reynaud's Disease
__ Varicose Veins
__ Blood Clots / Phlebitis

Nervous System
__ Dizziness
__ ALS
__ Multiple Sclerosis
__ Parkinson's Disease
__ Bell's Palsy
__ Neuritis
__ Spinal Cord Injury
__ Trigeminal Neuralgia
__ Seizures / Epilepsy

Other
__ Diabetes
__ Kidney Disease
__ Hepatitis
__ HIV / AIDS
__ Lupus
__ Postoperative: _____
__ Cystitis
__ High Stress
__ Grieving
__ Anxiety / Panic Attacks
__ Bipolar Syndrome
__ PMS / Menopause
__ Poor sleep / Insomnia

__ On a computer more than 2 hours per day. / No. of hours? ____

Respiratory
__ Pneumonia
__ Asthma
__ Breathing Problems
__ Sinusitis
__ Other: _____
_____

Skin
__ Fungal Infections
__ Athlete's Foot
__ Impetigo
__ Eczema / Dermatitis
__ Easily irritated skin
__ Other: _____

Allergies Affecting:
__ Facial / Body Skin
__ Nose / Sinuses
__ Eyes
__ Stomach / Gut
__ Orthopedic pins or plates
__ Other _____

Exercise
Times per Week: _____ Activities: _____

The above information is correct to the best of my knowledge. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for professional medical care. I agree to alert my practitioner of any physical / emotional changes as they occur. I also understand that a missed appointment might incur charges that I must pay.

Signature _____ Date_____

GOLD'S GYM WAIVER: I accept responsibility for my use of any and all apparatus, appliances, facility, privilege or service whatsoever owned and operated at this club at my own risk, including contract laborers, Weight Watchers, Massage Therapist, or any other third party renting space at Gold's Gym, and shall hold harmless it's owners, shareholders, directors, officers, employer's representatives from any and all loss, claim, injury, damage, or liability sustained or incurred by me resulting therefrom.

SIGNATURE: _____