

# GENESIS THERAPEUTIC MASSAGE

## CONFIDENTIAL INTAKE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Why are you coming in for massage?

What areas of your body do you feel tension/pain? Is the pain equal on both sides of your body?

Are there any areas on your body that you do NOT want massaged (such as hands or feet)?

Are there any areas that you would like specific focused massage on (such as neck, upper shoulders, low back)?

Please list Surgeries or Injuries or Accidents that are still affecting you (please include date of injury and if any treatment has been received).

List current medications including aspirin, ibuprofen, herbal remedies, blood pressure meds, etc.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Please mark any of the following you have now or have had in the past.**

<b><u>Nervous System</u></b>	<b><u>Circulatory</u></b>	<b><u>Musculoskeletal</u></b>
Shingles	Heart Condition	Bone or Joint disease
Numbness/Tingling	Phlebitis/Varicose Veins	Tendonitis/Bursitis
Trigeminal Neuralgia	Blood Clots	Arthritis/Gout
Bell's Palsy	High/Low Blood Pressure	Sprain/Strain
Sciatica	Lymphedema	Low back/hip/leg pain
Pinched Nerve	Thrombosis/Embolism	Neck/Shoulder/Arm pain
Other:	Other:	Spasms/Cramps
		Jaw Pain/TMJ
		Lupus
		Osteoporosis
		Scoliosis
		Other:
<b><u>Respiratory</u></b>	<b><u>Skin</u></b>	
Asthma	Allergies	
Emphysema	Rashes	
Allergies	Athletes Foot	
Sinus Problems	Herpes/Cold Sores	
<b><u>Reproductive</u></b>	<b><u>Digestive</u></b>	<b><u>Other</u></b>
Pregnant: Stage	Constipation/Diarrhea	Cancer/tumors
Ovarian/Menstrual Problems	Gas/Bloating	Kidney/Bladder Ailment
PMS	Diverticulitis	Diabetes ( I or II)
Prostate	IBS	Chronic Fatigue
Other:	Ulcers	Sleep Disorders
	Other:	Migraines/Headaches
		Anxiety/Stress
		Communicable Diseases
		(please specify)

I have listed all my known medical conditions and physical limitations and will inform the massage therapist in writing of any changes in my physical health between massage sessions. I understand that a massage therapist must be aware of any and all existing physical conditions that I have in order to provide appropriate massage. I further understand that a massage therapist neither diagnoses nor prescribes for illness, disease, or any other medical, physical or emotional disease, nor performs any thrusting joint or spinal manipulation or adjustments. I am responsible for consulting a qualified primary care provider for any physical ailment that I may have. **The massage therapist reserves the right to refuse services for reasons of safety, skills and abilities.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_