Abandon Your Aches Massage
Intake Form

Name: ____________________ Date: ____________ Birth Date: ________

Address: ____________________ City: ____________ State: ____ Zip: ______

Phone: ______________ E-Mail: ____________________

May I contact you at the above Phone: **Y** or **N** If **no**, how may I contact you? ______________
If I leave message, can I include: **appt info** or **call-back # only**

Employer: ______________ Work Phone: ____________ May I contact you here? Y N

Emergency Contact/Relationship: ______________ Phone: ____________

How did you hear about me? ____________________

Health History

Doctor: ____________ Clinic: ____________ Phone: ____________

What do you see your Dr. for? ____________________

Are you currently taking any substances? If so, please list below (Include herbs, homeopathic remedies, supplements, alcohol, recreational drugs and prescribed medications):

Please list any surgeries, injuries, or accidents (auto, skiing, horse, etc.) you've had:

Type of Injury/Surgery/Accident	Brief Description	Date

Please indicate and briefly explain history with the following (C=Current, P=Past, N=No):

General Systems

C P N Cardiovascular
(Heart, Blood Vessels, Blood, etc.)

C P N Endocrine
(Diabetes, Hypoglycemia, Hypothyroidism, etc.)

C P N Gastrointestinal
(Ulcers, Gastritis, Chron's Disease, Hepatitis, Gallstones, Pancreatitis, etc.)

C P N Immune
(HIV, AIDS, swollen glands, cold/flu, etc)

C P N Musculoskeletal
(Muscles & bones: osteoporosis, sprains, fibromyalgia, etc.)

C P N Neurological
(MS, Carpal Tunnel, etc.)

C P N Psychological
(PTSD, depression, bipolar disorder, etc)

C P N Reproductive
(PID, endometriosis, UTI, STD's, etc.)

C P N Respiratory
(Bronchitis, pneumonia, cystic fibrosis, emphysema, etc)

C P N Urinary
(Bladder/Kidney infections, etc)

C P N Integumentary (Skin)
(Acne, athlete's foot, herpes, etc.)

Specific Conditions

C P N Allergies (please list) ______________
C P N Arthritis
C P N Diabetes
C P N Hypertension
C P N Osteoporosis
C P N Cancer (type/date) ______________
C P N Other (please specify) ______________

General Health

C P N Stress
C P N Headaches
C P N Fever
C P N Inflammation/Swelling
C P N Pain
C P N Numbness
C P N Pregnancy
C P N Menstrual (pain)
C P N Abnormal Energy
C P N Sleep Problems
C P N Dietary Problems
C P N Communicable Disease

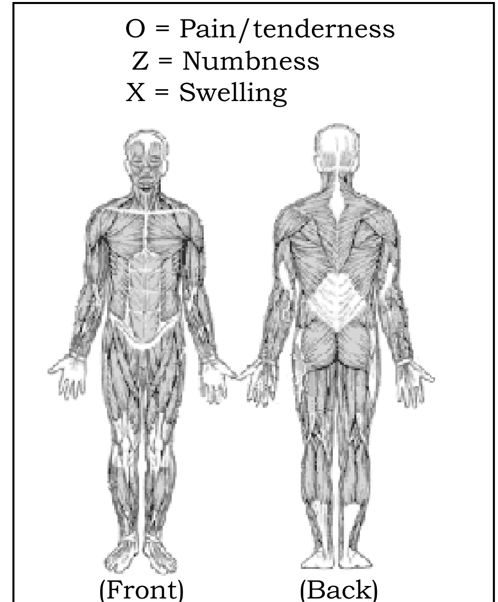
Have you had massage before? Y N Frequency: ____________ For: ____________

What were the results? ____________________

Name: ______________________________ Date: ____________________

Today's Massage:

What would you like from your massage today?
(Include areas you'd like specific attention or avoided)



Please also indicate severity of symptoms from 1-10
(1=I feel great, 10=I'd take child birth/kidney stones any day)
1 2 3 4 5 6 7 8 9 10

Is condition generally becoming ___ worse ___ better ___ same

Is there an activity that makes the symptoms worsen or subside?

Does your job or recreational activities affect the symptoms?

How often do you have these symptoms?

What is your ultimate goal for massage (even if it takes more than one session)?

Are you wearing contacts? (The face cradle may cause pressure on your eyes)

Consent for Care:
It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature ______________________________ Date ____________________

Auto Accident Info: (Fill out only if this applies to you)

What type of impact: _____ Hit from behind ______Hit on L / R side _______ Front _______Rollover
What area of your vehicle was damaged ______________________________
What was the approximate speed? Your vehicle______ other vehicle/object_______
Did you go to the ER? Y N What tests/x-rays were performed________________________
Besides Dr. referring you here and/or the ER, have you seen any other providers? If so, who?
____

Were there any results that would affect your massage?
____
____