Awaken For Wellness Massage Therapy Intake Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date:\_\_\_\_\_\_\_\_\_\_\_\_­­Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Day(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eve(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions by circling the appropriate answer: **(If “yes”, please write description on back)**

Have you had a professional massage before?.......................................................................... yes no

Please order 1 to 5 your reason for seeking massage: (1 being top priority)

Heal Injury\_\_\_ Headaches\_\_\_ Relax\_\_\_ Pain\_\_\_ Tension\_\_\_

Other reasons?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When you receive massage, would you say that you enjoy deep pressure? Yes No comment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on any medication (including pain killers/OTCs)…….…………………………………. yes no

Do you wear contact lenses?........ yes no Do you wear dentures?...................... yes no

Do you exercise regularly or participate in any sports?............................................................. yes no

Are you sensitive to perfumes, lotions, or oils?......................................................................... yes no

Do you have any skin problems or allergies?............................................................................. yes no

Do you have any heart problems?............................................................................................. yes no

Do you have high blood pressure?............................................................................................. yes no

Do you have varicose veins or blood clots?............................................................................... yes no

Do you have arthritis, osteoporosis, brittle bones, or spinal problems?................................... yes no

Do you have lung or breathing problems?................................................................................. yes no

Do you have digestive tract problems?...................................................................................... yes no

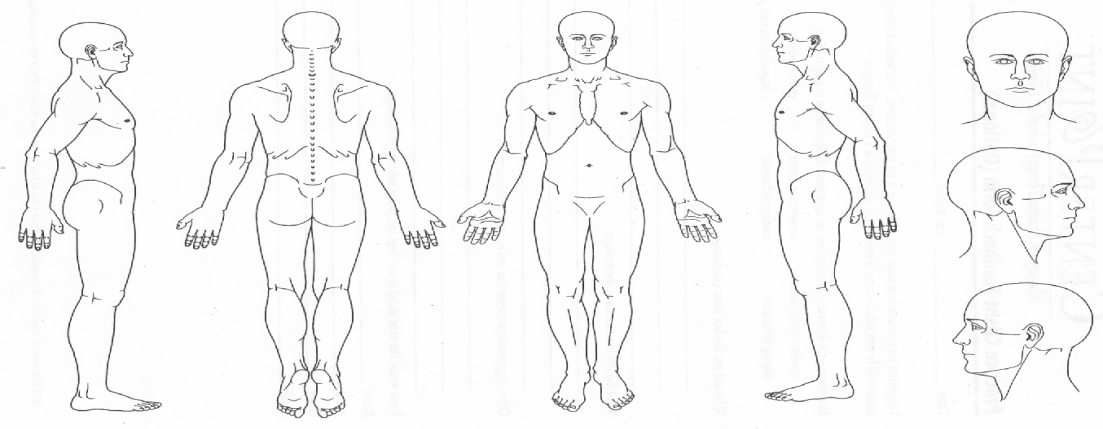
Are you pregnant?...................................................................................................................... yes no

Have you suffered any acute injuries or illnesses, or been hospitalized in the last year?......... yes no

Are you seeing a psychologist or counselor?.............................................................................. yes no

Do you have any other health concerns I should be aware of?.................................................. yes no

**Mark any areas of tension or soreness you would like therapist to address on figures below:**

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**Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Exercise or sports:**

Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_

**Skin problems or allergies:**

Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical opinion and treatment for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Heart Problems:**

Medical opinion and treatment for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Blood Pressure Problems:**

Medical opinion and treatment for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Varicose veins or Blood clots:**

Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical opinion and treatment for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Arthritis, osteoporosis, brittle bones, or spinal problems:**

Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical opinion and treatment for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Lung and Breathing Problems:**

Medical opinion and treatment for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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**Digestive tract problems:**

Medical opinion and treatment for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Acute injuries:**

Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:**

Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are seeing a therapist or counselor, are there issues in that work that may impact receiving massage?

Any other conditions the massage therapist should be aware of:

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing energy flow. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand that massage therapy is not a substitute for medical treatments and/or diagnosis and that it is recommended that I see a physician for any physician for any physical ailments that I may have. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. I have received and agree to the “client bill of rights” form as well as all content within this intake form.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_