Redefined Health

Massage Therapy Intake

Name _____ **Date** _____

Please indicate conditions you are experiencing or have experienced recently:

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chronic Congestive Heart Failure
- ❑ Phlebitis/Varicose Veins
- ❑ Stroke/CVA
- ❑ Pacemaker
- ❑ Heart Disease
- ❑ Dizziness
- ❑ Seizures
- ❑ Headaches/Migraines
- ❑ Numbness/Tingling
  Location: _____
- ❑ Asthma
- ❑ Emphysema
- ❑ Crohn's Disease
- ❑ Irritable Bowel Syndrome
- ❑ Constipation
- ❑ Diabetes
  Type: _____
- ❑ Epilepsy
- ❑ Cancer
  Type/Location: _____
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Scoliosis
- ❑ Osteoporosis
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Skin Condition
  Details: _____
- ❑ Eczema
- ❑ Psoriasis
- ❑ Rash
- ❑ Warts
- ❑ Open Sores
- ❑ Allergies
  Details: _____
- ❑ Pregnant
  Due Date: _____

Do you have any medical conditions not listed above? Yes No

If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? Yes No

_____

Have you ever been involved in any motor vehicle accidents? Yes No Year/Date: _____

Have you ever sustained any other significant injuries? Yes No

Details: _____

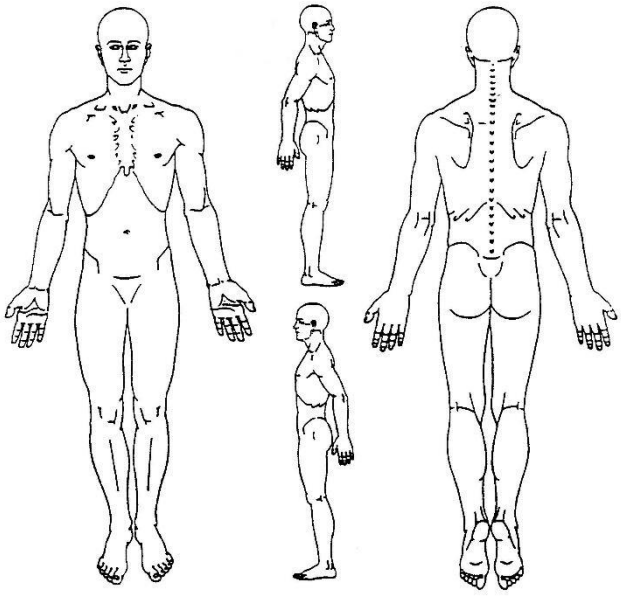
Briefly list any surgeries you have undergone, for what and when.

_____

_____

Redefined◦Health

Please mark areas which are currently causing you symptoms of discomfort



Have you previously received massage therapy treatments? Yes No

If so, when was your last treatment? _____

Please indicate goals you would like to achieve through massage therapy:

Relaxation Decrease Pain Increase Range of Motion Maintenance Achieve Fitness Goal

Other: _____

Please indicate if you would prefer a silent massage (minimal talking): Yes No

Have you seen any other health care professional(s) for this condition or reason? Yes No

If yes whom?

_____

Are you presently taking any prescribed medication(s)? Yes No

If yes, please list the medication(s) and the condition(s) for which it is being used (if known).

_____

_____

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

We understand circumstances arise, however, please note a fee may be applied for missed or cancelled appointments within 24 hours.

_____

Signature Date Therapist's Signature