

Intake Questionnaire

All client information is secure and confidential data subject to the Health Insurance Privacy and Portability Act. **Please Initial here.** _____

Name: _____ Sex _____ Date Of Birth _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Primary Phone: _____ Mobile Home Work

Secondary Phone: _____ Mobile Home Work

Emergency Contact: Name _____ Phone: _____

Referred by or read advertising in: _____

Have you had professional massage therapy before today? _____ Are you a regular massage client? _____

Activities of Daily Living (the type of activities involved in your daily routines: sitting, lifting, keyboarding, driving, exercise, etc.) _____

Reason for therapeutic massage (major goal or complaint): _____

What treatment have you had for this condition? _____

Is there anything which make your condition worse? _____

Sleeping position: Back ___ R. side ___ L. side ___ Stomach ___

Number of Pillows: 1 2 3 4

Please complete information on the back of this form.

The pressure of your massage should be:

Deep/Stress release Moderate Light/Nurturing

Are you currently being treated by any of the following medical providers? If yes, please check that apply. Medical Doctor: Chiropractor: Psychiatrist:

Please list any medication you are presently using and the propose:

Med. _____	Purpose: _____
Med. _____	Purpose: _____
Med. _____	Purpose: _____

Have you had any surgery? _____ If yes, please explain: _____

Please take a moment to carefully read the following information. If you have a specific medical condition or specific symptoms massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Please note if you have any of the following as a chronic condition.

AIDS Allergies Arthritis Asthma Back Pain Bursitis Cancer
 Chronic Fatigue Constipation Cramps Diabetes Dizziness HIV
 Leg Pain Neck Pain Phlebitis Poor Circulation Stroke Survivor of
Abuse Varicose Veins
Other Condition _____

I understand that the massage/bodywork I receive is provided for the basics purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform Carter so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness; an anything said in the course of the session given should not be construed as such. I affirm that I have read and answered fully and truthfully this intake questionnaire and have listed all my known medical condition. I further release of liability for failure to have to disclosed any relevant information.

Date: _____ Signature: _____