The Body Mechanic

Intake Form

Name:		**Date:**	
DOB:	**Phone:**	**Email:**	
Address:		**City/State:**	**Zip:**
Occupation:		**Referred By:**	
Emergency Contact:		**Relationship:**	
Phone:			

Please answer the following questions to the best of your knowledge as they will be used to help plan safe and effective sessions.

Have you had a professional massage before? Yes / No

Circle if you have pain when you lie on your stomach? Your back? Your side?

Do you have allergies to oils or lotions? Yes / No

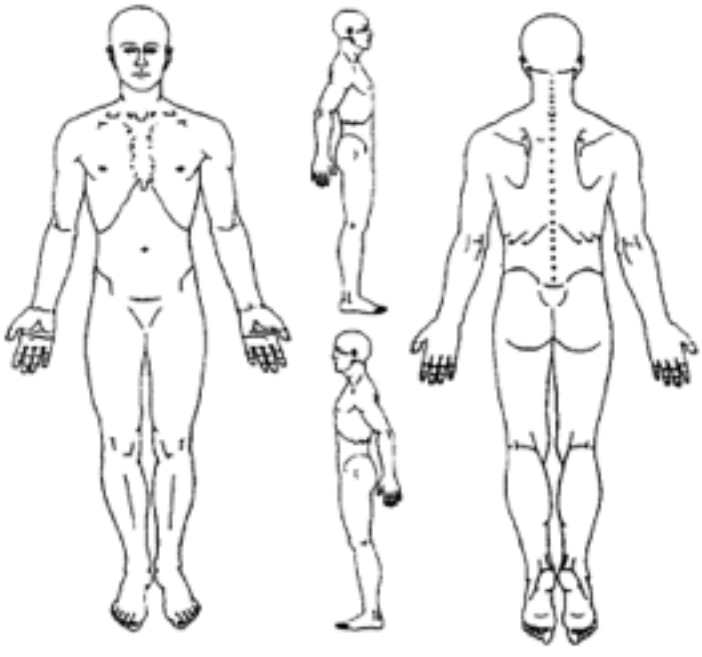
Are there certain area(s) of your body that you want avoided? Yes / No

Do you sit for long hours at a workstation, computer, or while driving? Yes / No

Do you perform repetitive movements in your work, sports, or hobby? Yes / No

Are there particular area(s) of the body where you experience pain or other discomforts? Yes / No

If yes, please mark the places where you experience pain:



Medical History:

Are you currently under the supervision of a medical professional? Y / N If yes, please explain: _____

Are you currently taking any medication? Y / N If yes, please list: _____

_____

Please check any of the following conditions that apply to you:

Musculoskeletal:

__ Headaches
__ Joint Stiffness/swelling
__ Spasms/Cramps
__ Back/hip pain
__ Shoulder/neck/arm/hand pain
__ Leg/foot pain
__ Chest/ribs/abdominal pain
__ Problems Walking
__ TMJ/jaw pain
__ Tendonitis
__ Bursitis
__ Arthritis
__ Osteoporosis
__ Scoliosis
__ Bone or joint pain
__ Broken/fractured bones

Skin:

__ Rashes
__ Warts
__ Athlete's foot

Circulatory/Respiratory:

__ Shortness of breath
__ Dizziness
__ Fainting
__ Cold feet or hands
__ Swollen ankles
__ Varicose veins
__ Blood clots
__ Stroke
__ Heart condition
__ Allergies
__ Sinus problems
__ Asthma
__ High blood pressure
__ Low blood pressure
__ Lymphedema

Digestive:

__ Constipation
__ Diverticulitis
__ IBS
__ Crohn's Disease

Nervous System:

__ Numbness/tingling
__ Chronic pain
__ Ulcers
__ Paralysis
__ Epilepsy
__ Chronic Fatigue
__ Multiple Sclerosis
__ Muscular Dystrophy
__ Parkinson's

Other:

__ Depression
__ Pregnant
__ Menopause
__ Diabetes
__ Fibromyalgia
__ Cancer

I, _____, understand 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 of effectiveness of individual techniques or a series of appointments. If I experience any pain or discomfort during any session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated about changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Sign: **Date:**