

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.

What symptoms are you experiencing and how long have they been a problem?

Do you have pain when opening mouth? (i.e. biting something large or yawning) Y/N

Do you have pain chewing something tough? (i.e. bagel or steak) Y/N

Does your pain slowly increase throughout the day or is it a sharp pain all at once? Y/N

Do you have noises in the jaw joint? Cracking? Clicking? Popping?

Do you have headaches? Y/N How often? _____

History of trauma to the jaw, face, head or neck? Y/N

Have you seen anyone else about this condition? Y/N

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

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

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: