movementplus

Advanced Institute of
Physical Therapy

MASSAGE THERAPY INTAKE FORM

PERSONAL INFORMATION

Name: _____ DOB: _____

Address: _____

_____ _____ _____

City State Zip code

Cell Phone: _____ Home Phone: _____ E-mail: _____

Emergency contact/relationship: _____ Phone: _____

Primary Physician: _____ Occupation: _____

MEDICAL INFORMATION

Put "X" if you have a history of any of the following

___ *Cancer*	___ *Blood clots/Circulatory Issues*	___ *Hypo/hypertension*	___ *Stroke*
___ *Diabetes*	___ *Joint replacement*	___ *Renal Dysfunction*	___ *Heart Attack*
___ *Neuropathy*	___ *Plantar Fasciitis*	___ *Fibromyalgia*	___ *Osteoporosis*
___ *Sciatica*	___ *Arthritis*	___ *Fractures*	___ *TMJ*
___*Eczema*	___ *Psoriasis*	___ *Pregnancy_____weeks*	

Put "X" if you have experienced any of the following in the last 6 months.

___ *Back Pain: Upper Mid Low*	___ *Neck Pain*	___ *Numbness/Tingling*	
___ *Shoulder Pain*	___ *Arm Pain*	___ *Wrist Pain*	___*Strain/Sprain*
___ *Leg Pain*	___ *Knee Pain*	___ *Ankle Pain*	___*Headaches/Migraines*

Are you currently taking any medications? ___ Yes ___ No

If yes, please list medications: _____

When was the last time you received body work?

_____

What are your goals/expectations for this massage?

_____

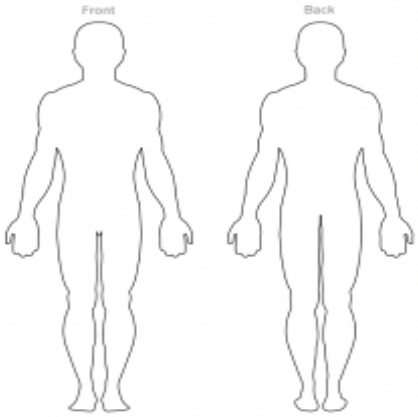
Do you have any allergies or sensitives to lotions or oils?

_____

Do you have any interest in the following? Put "X" that apply

__ Cupping ___ Aromatherapy ___ Prenatal Massage

*Please circle any areas of discomfort.



By signing the below, I agree to the following,

I have completed this form to the best of my knowledge and agree to inform the therapist if any of the information above changes at any time.

Signature: _____ Date: _____

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