ATHLETIC EDGE
MASSAGE THERAPY CLIENT HEALTH INTAKE FORM

PATIENT INFORMATION

NAME: ___________________________________________________________________
ADDRESS:________________________________________ CITY: ________________
STATE: _______ ZIP_________ HOME PHONE:____________________________
WORK PHONE: ________________________ CELL PHONE: ______________________
E-MAIL: __________________________________________________________________
OCCUPATION: _____________________________ DATE OF BIRTH: ______________
EMERGENCY CONTACT: __________________________ PHONE: ______________

ARE YOU CURRENTLY UNDER A PHYSICIANS CARE FOR AN ACUTE OR CHRONIC
ILLNESS?  Y _____  N ______
IF YES, PLEASE EXPLAIN __________________________________________________
IF YES, WHO IS YOUR HEALTH CARE PROVIDER: _____________________________

ARE YOU CURRENTLY TAKING ANY PRESCRIBED MEDICATION OR DIETARY
SUPPLEMENTS? Y _____  N ______
IF YES, PLEASE EXPLAIN __________________________________________________

HAVE YOU RECEIVED A MASSAGE BEFORE? Y _____  N _____
IF YES, WHEN: _________________________

HOW DID YOU HEAR ABOUT ATHLETIC EDGE: _____________________________

WHAT ARE YOUR GOALS FOR THIS SESSION: _______________________________

PLEASE LIST AREAS OF TENSION, STRESS AND/OR PAIN YOU WISH TO BE
ADDRESSED: _____________________________________________________________
________________________________________________________________________________

HEALTH INFORMATION

PLEASE MARK AND (X) BY ALL CURRENT CONDITIONS AND (P) FOR ALL PAST
CONDITIONS

__ Abdominal /digestive problems
__ Allergies
__ Anxiety
__ Arthritis/tendonitis
__ Asthma or lung cond.
__ Athletes foot
__ Blood clots
__ Chronic pain
__ Circulatory/heart problems
__ Constipation/diarrhea

__ Depression
__ Diabetes
__ Fatigue
__ Headaches, migraine
__ Hearing problems
__ Hernia
__ High blood pressure
__ Jaw pain/TMJ pain
__ Low blood pressure
__ Muscle/bone injuries
__ Muscle/joint pain
__ Numbness/tingling
__ Pregnancy
__ Rash/fungus
__ Sinus problems
__ Sleep difficulties
__ Spinal disorders
__ Sprain/strain
__ Tension/stress
__ Vision problems
__ Varicose veins
__ Other

ELABORATE ON NOTED ABOVE AREAS: __________________________________________
PLEASE LIST ANY RECENT INJURIES OR SURGERIES WITHIN THE PAST 5 YEARS: 
_________________________________________________________________________________
_________________________________________________________________________________

PLEASE LIST YOUR STRESS-REDUCTION ACTIVITIES, HOBBIES, EXERCISE, AND/OR SPORTS PARTICIPATION: ______________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

PLEASE USE THE LETTERS PROVIDED IN THE KEY TO IDENTIFY THE SYMPTOMS YOU ARE FEELING TODAY. CIRCLE THE AREA AROUND EACH LETTER, REPRESENTING THE SIZE AND SHAPE OF EACH SYMPTOM LOCATION.

I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction, and relief from muscular tension, spasm, or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis, and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute sexual harassment and will not be tolerated. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature: ___________________________ Date: ________________