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
_____

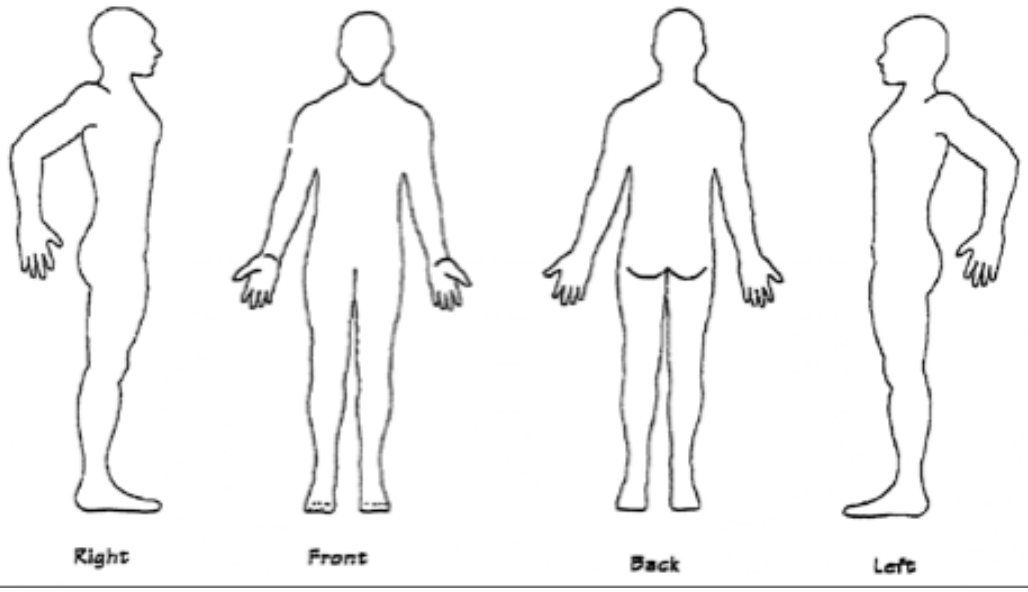
ELABORATE ON NOTED ABOVE AREAS: _____
_____

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.

P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling



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: _____