Massage Therapy at Crossroads

Confidential Massage Health Intake Form

Name: _____ ***Date:*** _____

<> In order to better assist you, please completely fill out this form, to the best of your knowledge <>

*****Please notify the receptionist if this is an SGI or WCB claim*****

Do you want a relaxation treatment or a deep tissue/therapeutic massage treatment? _____

Medical History

A.) In the last 6 months, have you received treatment from any of the following types of practitioners? (please circle)

- **Medical Physician**
- **Chiropractic Doctor**
- **Physiotherapist**
- **Massage Therapist**
- **Acupuncturist**
- **Naturopathic Doctor**
- **Other:** _____

What was the reason for above treatment: _____

B.) Have you been diagnosed or treated by a physician for any of the following?

Anemia	Depression	Bruise Easily
Anxiety	Diabetes	Neurological Condition
Allergies	Difficulty Swallowing	Multiple Sclerosis
Arthritis	Digestive Disorders	Numbness / Tingling
Asthma / Lung Disorders	Dizziness	Osteoporosis
Backaches / Bulged Disc	Epilepsy / Seizures	Psychiatric Condition
Bleeding Disorders / Clots	Fibromyalgia	Sleep Disturbance
Blood pressure	Fracture/broken bones	Skin Conditions
Cancer	Heart condition	Thyroid disease
Chronic Fatigue	TMJ (Lock Jaw)	Varicose Veins
Cholesterol	Headaches / Migraines	Whiplash
Circulatory Problems	HIV / Autoimmune	Other: _____
Concussion / Head Injury	Hepatitis / Liver Disease	_____
Constipation	Kidney Disorders	_____

C.) Are you taking any prescription, non-prescription medications, or herbal supplements?

Name(s) _____

Reasons _____

Family History

Is there a history of any of these conditions in your immediate family?

Arthritis	Kidney Disorders	Lung Disorders
Bleeding Disorders / Clots	Diabetes	Neurological condition
Blood Pressure	Digestive Disorders	Osteoporosis
Cancer	Fibromyalgia	Sleep Disturbance
Chronic Fatigue	Heart Condition	Thyroid disease
Cholesterol	TMJ (Lock Jaw)	Varicose Veins
Circulatory Problems	Headaches I Migraines	Other: _____
Depression	Hepatitis/Liver Disease	

Social & Physical Activity

- **Are you a smoker? Yes No**
- **Do you drink more then 5 glasses of water a day? Yes No**
- **Have you consumed any alcohol or pain meds. in the last 12 hours? Yes No**
- **Do you exercise? Yes No**
- **Are you doing intensive training? Yes No**
- **Do you stretch? Yes No**
- **Any Major Weight loss in the last 6 months? Yes No**
- **Please rate your stress from 1 to 10, 10 being severe _____**
- **Whom may we thank for referring you? _____**
- **Any other concerns you wish to share? _____**

_____

Therapist's Notes

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