Therese S Brown, LMT
100 Plantation Drive "TGO"
Titusville, Fl 32780
(321)302-9885
MA# 21947 MM# 16443

Massage Intake Form

GetYourBodyWell.com

Please complete this information to help the therapist get to know you and so your therapy can be customized to your needs. All of this information is important because it describes your lifestyle. This information is confidential is will only be used in the development of your massage therapy treatment plan.

Basic Data

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____ Age _____ Birth Date _____

Marital Status _____ Spouse's Name _____ Number of Children _____

Height _____ Weight _____ Whom can we thank for referring you? _____

Occupation _____ Email address _____

Work Status: _____Fulltime _____Part-time _____Homemaker _____Unemployed _____Student

Indicate if we are seeing you for an injury from: ____Auto _____Sports ___Work ____Other _____No Injury

Emergency Contact _____ Home Phone _____Cell Phone _____

Health History

Physical activities at work:

_____ % Sitting _____ % Standing _____%_____

_____ % Walking _____ % Computer _____%_____

_____ % Lifting _____ % Repetitive Motion _____%_____

List the amount of time spent on each daily activity when not at work.

_____ Sitting _____ Standing _____ Walking _____ Other

_____ Computer _____ Lifting _____ Exercise _____ Other

_____Video Games _____House Work _____Other _____ Other

Hobbies, leisure time, sports, & time spent: (Golf, Reading, Gardening, TV, Crafts, Etc.)

_____

_____

_____

Have you ever had a professional massage before? ___No ___Yes Frequency _____

When was your last massage? _____ What pressure do you prefer? _____ Light _____ Med _____ Deep

What results are you looking for from your massage? _____

Do you have any concerns about getting a massage? _____

General Health—Please check any illnesses or conditions you have now or had in the past

	Current	Past
Bone or Joint Disease		
Bursitis/Tendonitis		
Spasms/Cramps		
Broken/Fractured Bones		
Arthritis _____		
Heart Condition		
Vascular Problems		
Blood Clot		
Aneurysm		
Blood Pressure Low/High		
Edema		
Breathing Problems		
Sinus Problems		
Allergies		
Rash		
Athlete's Foot/Warts		
Sprains/Strains		
Back Pain		
Hip Pain		
Leg/Foot Pain		
Neck Pain		
Constipation		
Irritable Bowel		
Diverticulitis		
Herpes/Shingles		

	Current	Past
Chronic Pain		
Neuroma		
Fatigue		
Insomnia		
Sleep Disorder		
Pregnant _____ months		
Menopause		
Shoulder Pain		
Arm/Hand Pain		
Headache/Head Injury		
Lupus/Fibromyalgia		
Chronic Fatigue/Syndrome		
Cancer		
Diabetes		
Thyroid Problems		
Liver Disease		
Eating Disorders		
Depression		
Bipolar Disorder		
Drug/Alcohol Addition		
Infectious Disease:		
Other: _____		
Other: _____		
Other: _____		

List all medications and what they are for (including non-prescription): _____

Please list any old Injuries over a year ago and the dates of occurrence: _____

Please list any new Injuries less than 1 year and the dates of occurrence: _____

Surgeries and Date: _____

How much water do you drink daily? _____ Do you smoke? No Yes _____ Number per Day

Number of alcoholic drinks per day _____ Do you use illicit drugs? (Yes, I need to know.) No Yes

Nutrition and Diet: Check any that apply to you.

_____ Healthy w/meat or
_____ Vegetarian

_____ I try to eat healthy, but could do better

_____ I love junk food, snacks, fast food

_____ I take time to eat or
_____ I eat in a hurry

_____ I eat at my desk or in front of the TV

_____ I use sugar or
_____ I use sugar free products

_____ Number of servings of fruit/veggies per day

_____ I cook most of my food or
_____ I eat out a lot

_____ I eat alone or
_____ I eat with my family

_____ I worry about my weight

Consent

1. It is my choice to receive massage therapy.
2. I understand that massage therapy is beneficial for relaxation, relief from pain, tension, and stress.
3. I agree to communicate fully with my therapist in regard to my health and massage experience.
4. I understand that massage therapists do not diagnose illness, disease, or mental disorders, nor do they prescribe any medical treatment, pharmaceuticals, or perform any spinal manipulations.
5. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is advised that I see a primary care provider for that service.
6. I have truthfully stated all medical and health conditions that I am aware of, and will inform the therapist of any changes in my health status.
7. I am aware that not informing the therapist of critical health information could result in injury due to contraindications for massage.

_____ _____

Patient Signature or Legal Guardian Date

Therese S Brown
Licensed Massage Therapist