

Milwaukee's Best Massage Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Today's Date _____
Length of Session _____
Therapist's Name _____

Name _____ Date of birth _____
 Address _____
 State _____ City _____ How did you hear about our services? _____
 Best phone number to reach you at _____ Occupation _____
 Email address _____

Have you ever received massage therapy? ___Yes ___No
 If yes, when was the last time you had a massage? _____
 How often do you get massaged? _____

Place a check next to massage styles you have experienced Swedish Acupressure Relaxation
Deep tissue Chair Lomilomi Sports Polarity Therapy Esalen Energy Thai/Asian
Four-hand Couples

Are you currently taking any medications? ___Yes ___No
 If yes, please list name and reason for medications _____

Are you currently seeing a healthcare professional? ___Yes ___No
 If yes, please list names and reason/treatment _____

Please review this list and place an X next to those conditions that have affected your health either recently or in the past.

- | | | |
|------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> depression, panic disorder, | <input type="checkbox"/> stroke |
| <input type="checkbox"/> auto-immune condition* | <input type="checkbox"/> other psych condition | <input type="checkbox"/> surgery |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> diverticulitis | <input type="checkbox"/> TMJ disorder |
| <input type="checkbox"/> back problems | <input type="checkbox"/> headaches | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> heart conditions | <input type="checkbox"/> seizures |
| <input type="checkbox"/> broken/dislocated bones | <input type="checkbox"/> hepatitis (A, B, C, other) | <input type="checkbox"/> stress |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> skin conditions | <input type="checkbox"/> whiplash |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure | |
| <input type="checkbox"/> chemical dependency
(alcohol, drugs) | <input type="checkbox"/> insomnia | (*AIDS, fibromyalgia, chronic
fatigue, lupus, etc.) |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> negative people/events | |
| <input type="checkbox"/> constipation/diarrhea | <input type="checkbox"/> muscle strain/sprain | |
| | <input type="checkbox"/> pregnancy | |

If any of the above needs to be detailed or if there is anything else to share, please do so: _____

Do you have any of the following today: ___ skin rash ___ cold/flu ___ open cuts ___ severe pain
 ___ anything contagious ___ injuries/bruises

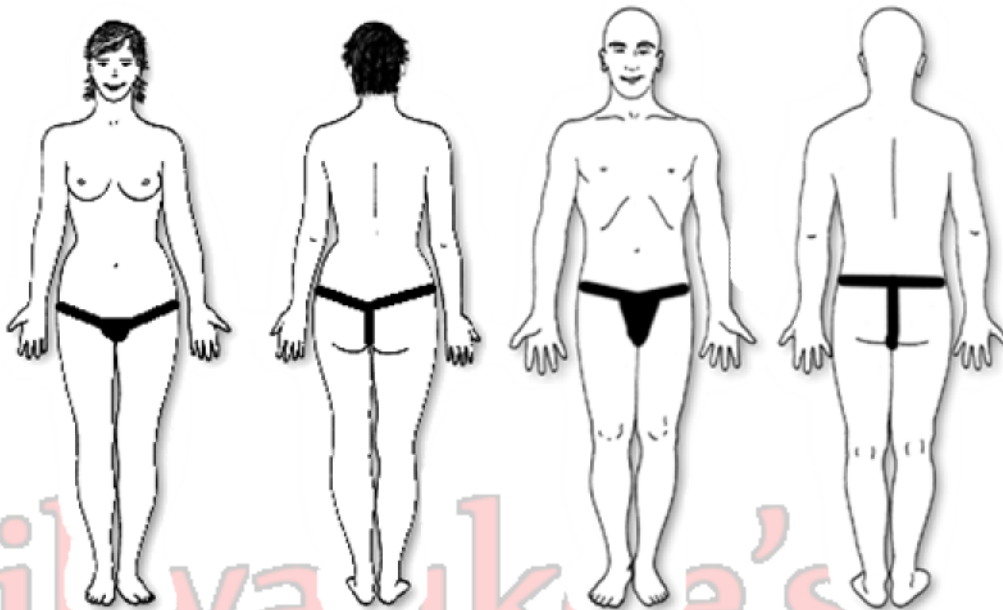
Do you have any allergies to: ___ medications ___ foods (nuts, etc.)
 ___ environmental allergens (dust, pollen, fragrances) ___ reactions to skin care products

If any of the above are Xed, please give details: _____

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Are you wearing: ___ contact lenses ___ hearing aid ___ hairpiece ___ prosthetics?

Please indicate with an (X), if any, the areas in which you are feeling pain or discomfort today:



Although this is a full body massage, are there any areas that you do NOT want worked on? ___ Yes ___ No

If **yes**, please specify off-limit areas. scalp face chest stomach feet hands thighs
 butt other _____

What are your goals/expectations for this therapy session? _____

The following sometimes occurs during massage: the need to move or change position ✪ sighing, yawning, change in breathing ✪ stomach gurgling ✪ emotional feelings and/or expression ✪ movement of intestinal gas ✪ energy shifts ✪ falling asleep ✪ memories ✪ stimulation of sympathetic system. These are all normal responses to relaxation and massage. Trust your body to express what it needs to.

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual advances or requests that are sexual in nature will terminate the session and I will be liable for payment of the scheduled treatment. I also understand that local and state law requires that the genital area be draped at all times.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____

Date _____