Optimized Integrative Health
Massage Therapy Intake Form

Name: _____ Date of Birth:___/___/____

Address:_____City:_____ State:_____Zip: _____

Preferred Contact #:(____)_____-_____ Email:_____

In case of an Emergency who should we contact?

Name:_____ Phone #(____)_____-_____Relationship:_____

Medical Conditions

Please circle if you ever had or you currently have any of the following medical conditions?

Heart Attack / Stroke	Arthritis	Ringing in Ears
Congenital Heart Defect	Frequent Neck Pain	Dizziness
Alcohol / Drug Abuse	Jaw Pain	Kidney Problems
Fainting / Seizures / Epilepsy	Wrist Pain	Cancer
Shingles	Shoulder Pain	HIV / AIDS
Psychiatric Problems	Arm Pain	Artificial Bones Joints
Difficulty Breathing	Leg Pain	Severe / Frequent Headaches
Hepatitis	Lower Back Problems	Diabetes / Tuberculosis
Anemia	Severe / Frequent Earaches	Emphysema
Ulcer / Colitis	Gout	Glaucoma

Numbness, where?_____Tingling, where?_____Muscle Spasms, where?_____

Areas where you prefer **NOT** to be massaged:_____

Surgeries

Please list any and all surgeries with the dates they were performed:_____

_____

_____

_____

I, _____, understand that the massage therapy given here is for the purpose of stress reduction, relief of muscular tension or spasm, or increasing circulation. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist prescribed neither medical treatment, pharmaceuticals, nor performs spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and / or diagnosis, and that it is recommended that I see a physician for any physical ailment that I may have.

_____ Date:_____

Signature (If minor, Parents / Legal Guardian)