

**Women's Wellness Center
Massage Therapy**

Massage Intake Form - CONFIDENTIAL INFORMATION

WELCOME! We would like your massage experience to be as pleasant and therapeutic as possible. If at any time you have questions regarding your session, please let your therapist know. Relax and enjoy!

Name _____ Date of Birth _____

Have you ever received massage therapy? Yes No

Type of massage experience desired? _____

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

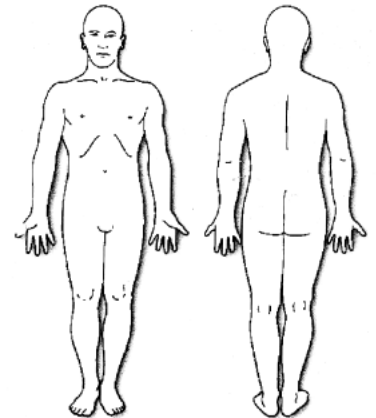
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|-------------------------|-----------------------|----------------------------|
| currently pregnant | diabetes | auto-immune condition |
| arthritis | high blood pressure | lupus |
| chronic pain | heart conditions | HIV/AIDS |
| headaches | blood clots | hepatitis (A, B, C, other) |
| back problems | stroke | cancer |
| scoliosis | surgery | seizures |
| whiplash | constipation/diarrhea | anxiety, panic disorder |
| broken/dislocated bones | rash, open cut | depression |
| muscle strain/sprain | skin conditions | chemical dependency |
| TMJ disorder | bruise easily | (alcohol, drugs) |

Please list name and reason for medications _____

Have you had a fever, cold or flu symptoms in the last 24 hours? Yes No

Do you have any allergies? _____

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



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

The following sensations sometime occur during massage. They are normal responses

to relaxation: *The need to move or change position ▪ Sighing ▪ Yawning ▪ Change in breathing ▪ Stomach gurgling*
▪ Feelings of emotion or recalling memories ▪ Movement of intestinal gas ▪ A shift in energy ▪ Falling asleep

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. Since massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature _____ Date _____