



## MESSAGE IN-TAKE FORM

David B. Finlayson LMT, NCTM

Name			
Address			
City, State, Zip			
Phone	(    )	E-Mail	
Date of Birth		Occupation	
Referred By			
Primary Physician			

Have you ever received a massage before? <input type="checkbox"/> Yes <input type="checkbox"/> No
How did you find out about us?
Area(s) you need extra attention?
Pain Level <i>(Scale of 1 → 10)</i>
Are you taking medication? If yes, please describe:
Emergency contact & relationship to you: <span style="float: right;">Phone</span>

<b>Do you have a history of any of the following?</b>			
<input type="checkbox"/> neck pain <input type="checkbox"/> whiplash <input type="checkbox"/> headache <input type="checkbox"/> disk problems <input type="checkbox"/> mid-back pain <input type="checkbox"/> low-back pain <input type="checkbox"/> joint ache or issues <input type="checkbox"/> decreased range of motion <input type="checkbox"/> pregnant <input type="checkbox"/> carpal tunnel <input type="checkbox"/> sciatica <input type="checkbox"/> leg cramps <input type="checkbox"/> wear contacts <input type="checkbox"/> wear prosthesis <input type="checkbox"/> sprain /strains	<input type="checkbox"/> swelling <input type="checkbox"/> abdominal pain <input type="checkbox"/> hypertension <input type="checkbox"/> bursitis <input type="checkbox"/> arthritis <input type="checkbox"/> gout <input type="checkbox"/> allergies <i>Including oils or perfumes</i> <input type="checkbox"/> varicose veins <input type="checkbox"/> low blood pressure <input type="checkbox"/> stroke <input type="checkbox"/> heart attack <input type="checkbox"/> blood clot <input type="checkbox"/> phlebitis <input type="checkbox"/> skin disorders <input type="checkbox"/> athletes foot <input type="checkbox"/> diabetes	<input type="checkbox"/> anemia <input type="checkbox"/> epilepsy <input type="checkbox"/> seizures <input type="checkbox"/> colitis <input type="checkbox"/> hypoglycemia <input type="checkbox"/> hyperglycemia <input type="checkbox"/> hepatitis's A, B or C <input type="checkbox"/> sunburn <input type="checkbox"/> tuberculosis <input type="checkbox"/> fatigue <input type="checkbox"/> insomnia <input type="checkbox"/> anemia <input type="checkbox"/> bladder infection <input type="checkbox"/> uterine bleeding <input type="checkbox"/> abdominal cramping <input type="checkbox"/> severe pain	<input type="checkbox"/> edema / swelling <input type="checkbox"/> osteoporosis <input type="checkbox"/> broken bone(s) <input type="checkbox"/> inflammations or infections <input type="checkbox"/> fever <input type="checkbox"/> HIV <input type="checkbox"/> cancer <input type="checkbox"/> open cut or bruises <input type="checkbox"/> burns <input type="checkbox"/> poison oak <input type="checkbox"/> cold / flu <input type="checkbox"/> contagious conditions <input type="checkbox"/> accident or injury <input type="checkbox"/> asthma

**Other:**

*See other side.*

# MASSAGE INTAKE FORM

Mark areas of anatomy in which you need help.  
What specifically would you like to receive from  
this massage?

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*If any of the health issues in this form apply to me, I will, prior to having the massage, discuss the conditions with you and provide to you a medical release for massage signed by my health care provider.*

*I have completed this health form to the best of my knowledge. I understand that massage is a health aid and does not take the place of a physician's care. Any information exchanged during a massage session is confidential and is only used to provide me with the best health care services.*

*I have stated all of my known medical conditions on this Intake Form. I have consulted a medical doctor or licensed medical health care practitioner regarding these conditions. I realize it is solely my responsibility to keep the bodywork practitioner updated on any changes in my physical health and I understand that Occupational Therapy of Gadsden, LLC and the massage therapist practitioner shall not be liable should I fail to do so.*

*If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance. If I miss a scheduled appointment without giving 24 notice, I agree to pay any missed appointment charge.*

Client Signature: \_\_\_\_\_ date \_\_\_\_/\_\_\_\_/\_\_\_\_

## David B. Finlayson LMT, NCTM

*Nationally Certified in Therapeutic Massage*

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