PHYSICAL THERAPY U
LEARN REHAB RECOVER

Massage Intake

Name _____ DoB: _____ ___

Phone _____ Email _____

Address _____ City/ State _____ Zip _____

Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Physician _____ Phone _____

Who referred you?_____

Consent for Treatment

I, the undersigned, do hereby authorized the licensed massage therapist to administer treatment as they deem necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand that the massage given to me is for: stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons discussed with massage therapist.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

Cancellation/No-Show Policy

I understand that cancellations should be made at least 4 hours before the scheduled appointment time, unless extenuating circumstances prevent otherwise. The fee for no-shows or cancelations is $35.00. An appointment will be classified as a no-show if cancellations are not made prior to appointment time.

By signing below, you are agreeing to all of the above terms and conditions.

_____ _____

Patient or Legal Guardian's Signature Date

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Medical Information

Are you taking any medications? □ Yes □ No

If Yes, please list name and use: _____

_____

Are you Currently Pregnant? □ Yes □ No

Do you suffer from chronic pain? □ Yes □ No

If Yes, Please explain: _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? □ Yes □ No

If Yes, please list:

Please indicate any of the following that apply to you:

□ Cancer
□ Fibromyalgia
□ Headaches/ Migraines
□ Stroke
□ Arthritis
□ Heart Attack
□ Diabetes
□ Kidney Disfunction
□ Joint Replacement(s)
□ Blood Clots
□ High/ Low Blood Pressure
□ Numbness
□ Neuropathy
□ Sprains or Strains
□ Skin Allergies/ Skin Sensitivities
□ Covid-19

Explain any conditions you have marked above:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? □ Yes □ No

What type of massage are you seeking?

□ Relaxation □ Therapeutic/ Deep Tissue

Other _____

What pressure do you prefer?

□ Light □ Medium □ Deep

Are there any areas (feet, face, abdomen, etc.) that you do not want massaged? □ Yes □ No

Please explain:

What are your goals for this treatment session?

Please circle any areas of discomfort

By signing below, you agree to the following:
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____

Therapist Signature _____ Date _____