Massageville Inc. 75 Cavalier Blvd
Suite #312, Florence, KY 41042

Please let us know if you have any allergies to nuts.

Massage Therapy Intake Form

Name:_____ Date of Birth:_____
Home Phone: ( )_____Work Phone: ( )_____Cell Phone: ( )_____
E-mail address:_____
Address:_____City:_____St:_____Zip:_____
Referred by:_____ Have you ever had a professional massage before?_____
If so, how often?_____ Do you exercise?_____ Frequency:_____
Please describe what type of exercise _____
Other daily activities:_____ Occupation:_____
Primary Care Physician:_____ Chiropractor: _____
How do you relieve stress or pain?_____

What are the reasons for your visit today?
What are your other health concerns?
Describe any surgeries you have had:
Describe any accidents you have had:
List all conditions currently monitored by a Health Care Provider:
List any medications that you took today:

Please note all current and previous conditions:

Headache	Y	N	Stiff/painful joints	Y	N
Sleep Problems	Y	N	Neck, shoulder, or arm pain or numbness	Y	N
Fatigue	Y	N	Low back, hip or leg pain or numbness	Y	N
Flu or cold symptoms in the last 48 hours	Y	N	Sciatica	Y	N
Sinus	Y	N	Depression	Y	N
Allergies to scents or lotions	Y	N	Blood clots	Y	N
Allergies, in general	Y	N	Stroke	Y	N
Arthritis	Y	N	Heart disease	Y	N
Osteoporosis	Y	N	High/low blood pressure	Y	N
Scoliosis	Y	N	Poor circulation	Y	N
Broken bones	Y	N	Asthma	Y	N
Disc problems	Y	N	Thyroid dysfunction	Y	N
Spasms/cramps	Y	N	Diabetes	Y	N
TMJ (jaw pain)	Y	N	Currently pregnant (If Yes see below)	Y	N
Tendonitis/bursitis	Y	N	Malignant cancer or tumors	Y	N
Spinal Problems	Y	N	Benign cancer or tumors	Y	N
Varicose Veins	Y	N	Pregnant Females: How far along is your pregnancy?		Weeks

Describe, as needed, any conditions indicated above, or other conditions that you feel may be important

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Contract for care:

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my Massage Therapist and other members of my health care team. I agree to participate in the self-care program that we select. I promise to inform my health care team any time I feel my well-being is threatened or compromised. I expect my Massage Therapist to provide safe and effective treatment.

Please Note:

Massage appointments are scheduled for a 1 hour period which includes time for undressing/dressing and the completion of an Intake Form for all new clients. Massages are stopped 5 minutes prior to allotted appointment time to allow clients time to change.

We encourage our clients to be early for appointments to complete all required Intake Forms. Unfortunately late appointment arrivals will result in shortening of session. We will gladly reschedule your appointment in an effort to keep you from loosing time in your session.

Consent for care:

It is my choice to receive massage therapy, and I give consent to receive treatment. I understand that Massage Therapists DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for medical examination and/or diagnosis. I affirm that I have stated all my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so.

Signature:_____Date:_____

Signature of parent/guardian:_____Date:_____
(if patient is a minor)

If you are unable to keep your appointment, please give 24 hours notice.