**PressurePerfect Massage**

**Confidential Client Intake Form**

*Your answers to the following questions will help your therapist*

*tailor your massage to address your particular needs.*

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Which # is best to use?\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your primary reason for visiting us today (choose as many as are applicable):

 \_\_\_\_\_\_\_\_\_pain reduction \_\_\_\_\_\_\_\_\_\_stress/tension relief \_\_\_\_\_\_\_\_\_\_relaxation

Describe your pain/discomfort. Include aches, injuries, surgeries, medical conditions, related work-condition

concerns (e.g. ergonomics; lots of driving), and anything else you consider to be relevant.

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Please circle any of the following that pertain to you:

Varicose Veins Unusual stress levels

Phlebitis Known spinal or disc problems

Thrombosis Migraine headaches

Abdominal hernia Tendonitis

Tumors Irregular heartbeat

Cancer Vertigo

Lymphangitis Apnea

Skin infection or ulceration Arthritis

Acute fever Fibromyalgia

Varicosities Multiple Sclerosis

Peptic ulcer Other Autoimmune Disorders (please specify):

Hemophilia Pregnancy

Aneurysm Diabetes

Hypertension

Intermittent claudication-pain in the legs which worsens on exertion

Acute osteomyelitis, tubercular joints, or any infectious bone or joint disease

Cardiac Disease

Please list any other condition you feel we should know about:

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 (over please)

Please list the name and phone number of physicians or health care providers you are seeing relative to the

the reason came to see us today (***if you want us to consult w/ them regarding your massage***).

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Please list medications you currently take (especially blood thinners, statins, steroids, anti-inflammatory agents):

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Describe your health goals:

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Do you currently exercise and if so, describe your fitness activities/program.

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Please prioritize your problem areas...what should we concentrate on the most/least? On a scale from 1 to 10 (10 the worst) how would your rate your discomfort level in each area today?

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Are there areas of your body should your therapist avoid? (ie face, scalp, glutes, recent surgical site, etc.) *Breasts and genital areas are never exposed or touched.*

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Have you ever had a massage before? \_\_\_\_\_\_\_\_\_\_\_ How long ago was your last massage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you know if you prefer deep, moderate, or light pressure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*I understand that massage therapy is not without risk and that under some circumstances massage is contraindicated. I understand that it is my responsibility to disclose to my therapist any and all conditions that may affect his or her decision about the safety of addressing my condition(s) through soft tissue therapy. I have done so to the best of my ability. I further understand that depending upon the level of pressure I request, and my sensitivity, some soreness may occur after my massage and that a few individuals may even experience light bruising during deep tissue work. I consent to being worked on by a PressurePerfect Massage therapist.*

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 Signature Date