

# BAY TENNIS & FITNESS

## Massage Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

State \_\_\_\_\_ City \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Have you ever received massage therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.) \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list name and reason for medications \_\_\_\_\_

\_\_\_\_\_

Are you currently seeing a healthcare professional? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list names and reason/treatment \_\_\_\_\_

\_\_\_\_\_

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.

\_\_\_ arthritis  
\_\_\_ diabetes  
\_\_\_ blood clots  
\_\_\_ broken/dislocated bones  
\_\_\_ bruise easily  
\_\_\_ cancer  
\_\_\_ chronic pain  
\_\_\_ constipation/diarrhea  
\_\_\_ auto-immune condition\*  
\_\_\_ hepatitis (A, B, C, other)  
\_\_\_ skin conditions  
\_\_\_ stroke  
\_\_\_ surgery  
\_\_\_ TMJ disorder

\_\_\_ depression, panic disorder, other psych  
condition  
\_\_\_ diverticulitis  
\_\_\_ headaches  
\_\_\_ heart conditions  
\_\_\_ back problems  
\_\_\_ high blood pressure  
\_\_\_ insomnia  
\_\_\_ muscle strain/sprain  
\_\_\_ pregnancy  
\_\_\_ scoliosis  
\_\_\_ seizures  
\_\_\_ whiplash  
\_\_\_ chemical dependency (alcohol, drugs)

(\*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share,

please do so: \_\_\_\_\_

\_\_\_\_\_

Do you have any of the following today:

\_\_\_\_\_ skin rash    \_\_\_\_\_ cold/flu    \_\_\_\_\_ open cuts    \_\_\_\_\_ severe pain  
\_\_\_\_\_ anything contagious    \_\_\_\_\_ injuries/bruises

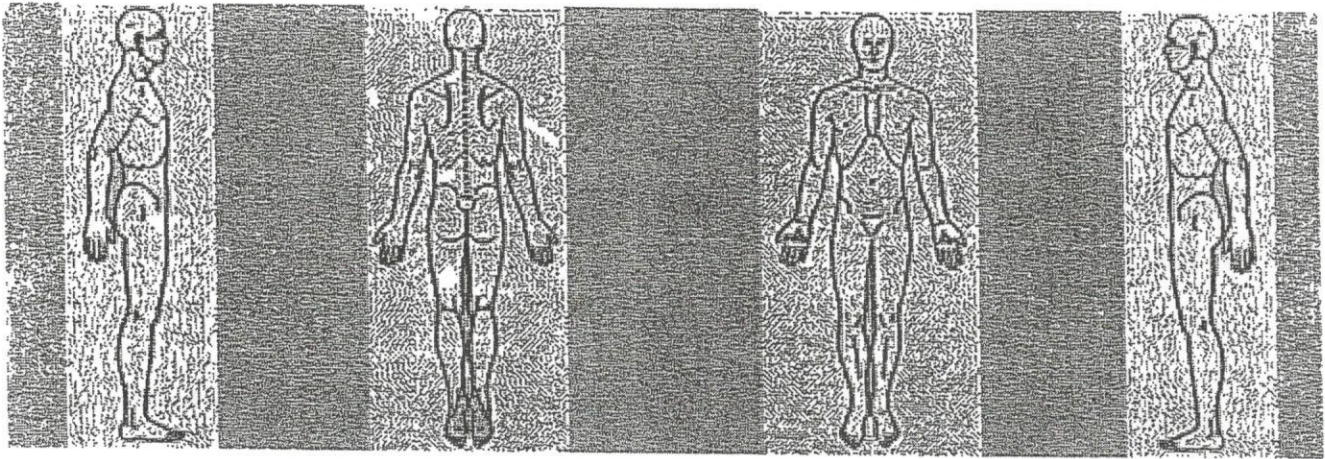
Do you have any allergies to:

\_\_\_\_\_ medications    \_\_\_\_\_ foods (nuts, etc.)  
\_\_\_\_\_ environmental allergens (dust, pollen, fragrances)  
\_\_\_\_\_ reactions to skin care products

If any of the above are checked, please give details: \_\_\_\_\_

Are you wearing: \_\_\_\_\_ contact lenses    \_\_\_\_\_ hearing aid    \_\_\_\_\_ hairpiece

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



What are your goals/expectations for this therapy session? \_\_\_\_\_

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:  
need to move or change position ❖ sighing, yawning, change in breathing  
stomach gurgling ❖ emotional feelings and/or expression  
movement of intestinal gas ❖ energy shifts ❖ falling asleep ❖ memories

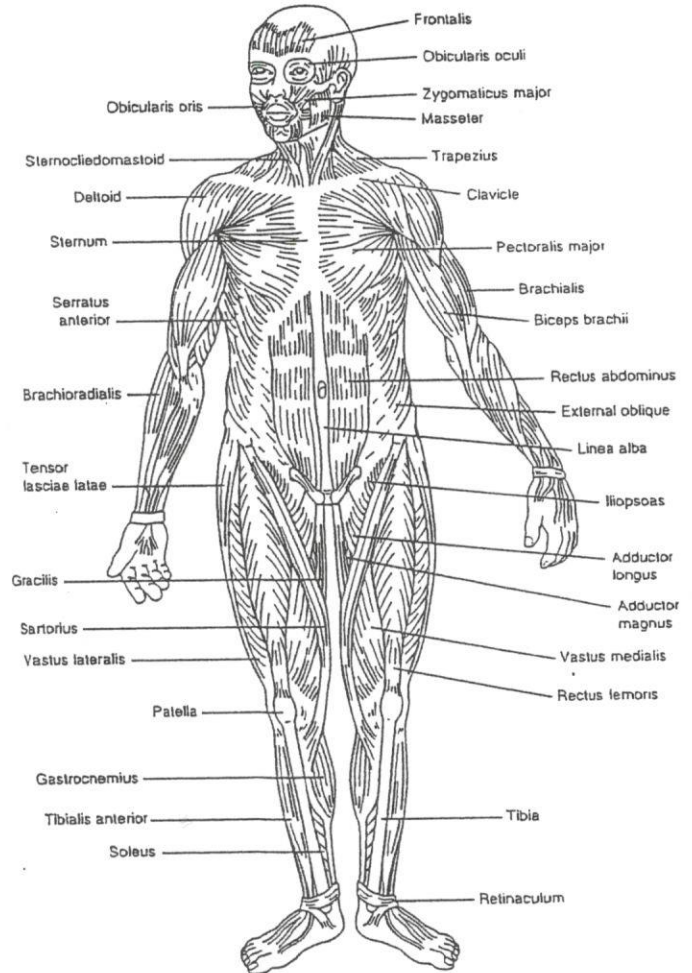
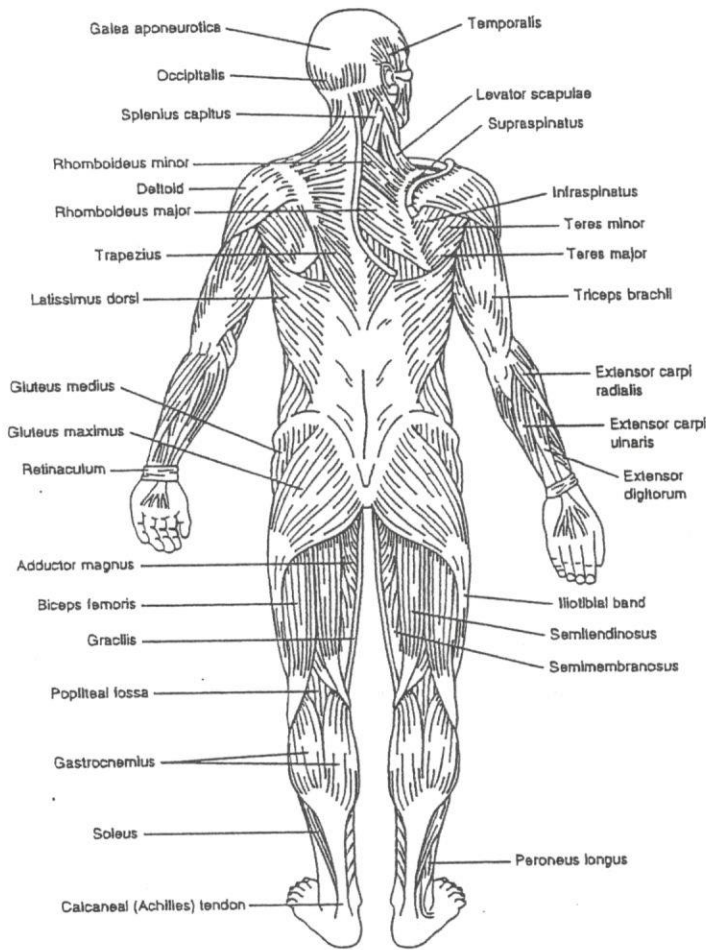
Please read the following information and sign below:

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. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name \_\_\_\_\_  
 Therapist \_\_\_\_\_  
 Date \_\_\_\_\_



Notes \_\_\_\_\_  
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