Beth T. Murray Massage Therapy

Massage Therapy Intake Form

Date: _____________

Name: ____ Date of Birth: ______________________

Address:____

City: _______________________________ State: ________ Zip Code: ______________________________

Cell Phone: __________________________________ Home Phone: _________________________________

Email:_______________________________________ Occupation: ___________________________________

Emergency Contact name and number:____

- Are you currently taking any medications? _____ Yes _____ No

If yes, please list name and reason for medication: ____

____

____

- Are currently seeing a *healthcare professional*? _____ Yes _____ No

If yes, please list name and reason for medication: ____

____

____

- Do you have *allergies* (including food and topical products)? _____ Yes _____ No

If yes, please list: ____

____

____

Please review this list and circle those conditions that have affected your health either recently or in the past. Place a check mark next to the condition

arthritis	depression	panic disorder	diabetes
Diverticulitis	blood clots	headaches	broken/dislocated bones
heart conditions	bruise easily	back problems	cancer
high blood pressure	chronic pain	insomnia	constipation / diarrhea
muscle strain / sprain	pregnancy	hepatitis (A, B, C, other)	scoliosis
skin conditions	seizures	stroke	whiplash
surgery	varicose veins	TMJ disorder	fibromyalgia
auto-immune condition	lupus		

- If any of the above needs to be detailed or if there is anything else to share, please do so here:

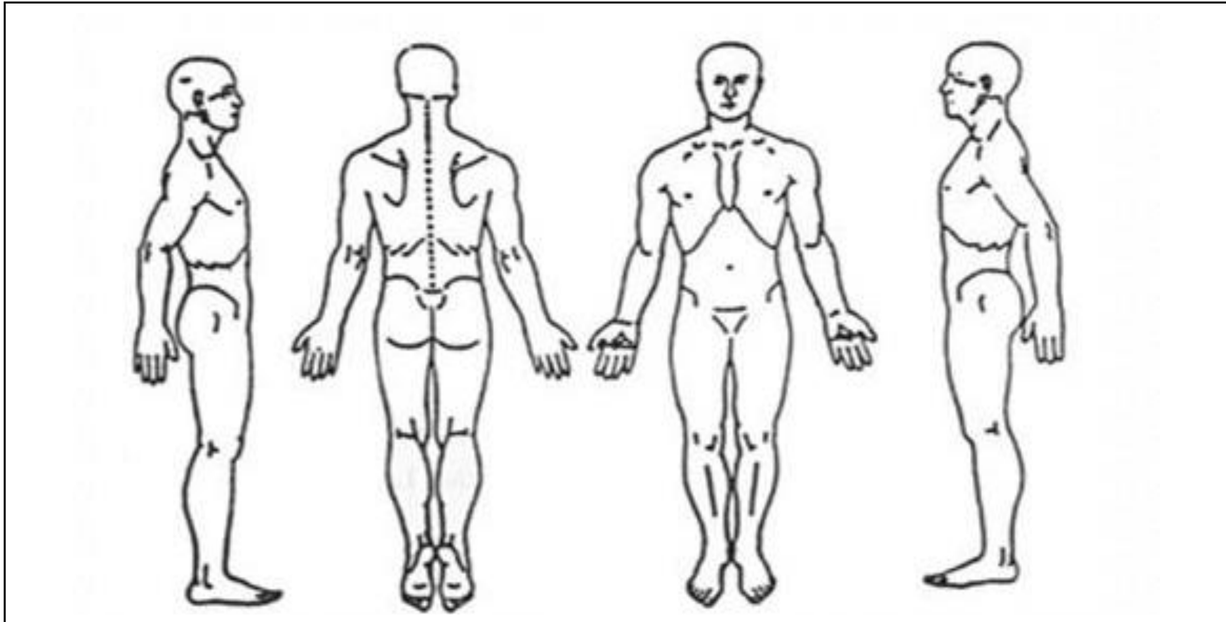
____

____

Beth T. Murray Massage Therapy

- Have you ever received massage therapy? _____ Yes _____ No
- What are your goals / expectations for this therapy session? ________________________________
  ____

- Please mark the drawing below to indicate where you hold your tension, pain or discomfort:



May I leave messages at the phone number(s) listed above regarding appointment? Yes No

May I add you to the my mailing list? Your information will **not** be shared. Yes No

Massage Therapy Informed Consent: Please read the information below and sign.

- I understand that massage therapy provided is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, and offer a positive experience of touch.
- I am aware the massage therapist does not diagnose illness or disease, does not prescribe medication, and that spinal manipulations are not part of the massage therapy.
- I have informed the massage therapist of all my known physical conditions, medications and medication. And will keep the massage therapist updated on my changes.
- 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.

Client's Signature: ___________________________________ Date: ____________

THANK YOU for choosing Beth T. Murray Massage Therapy