



## Massage Patient In-Take Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone Number \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_

Referred By \_\_\_\_\_

Emergency Contact

(Name) \_\_\_\_\_

(Phone number) \_\_\_\_\_ Relationship \_\_\_\_\_

Family Physician

(Name) \_\_\_\_\_ (Phone number) \_\_\_\_\_

Reason for Today's Visit/Health Goals You Would Like to Achieve

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Medical History (ex: surgery, trauma, major health incidents)

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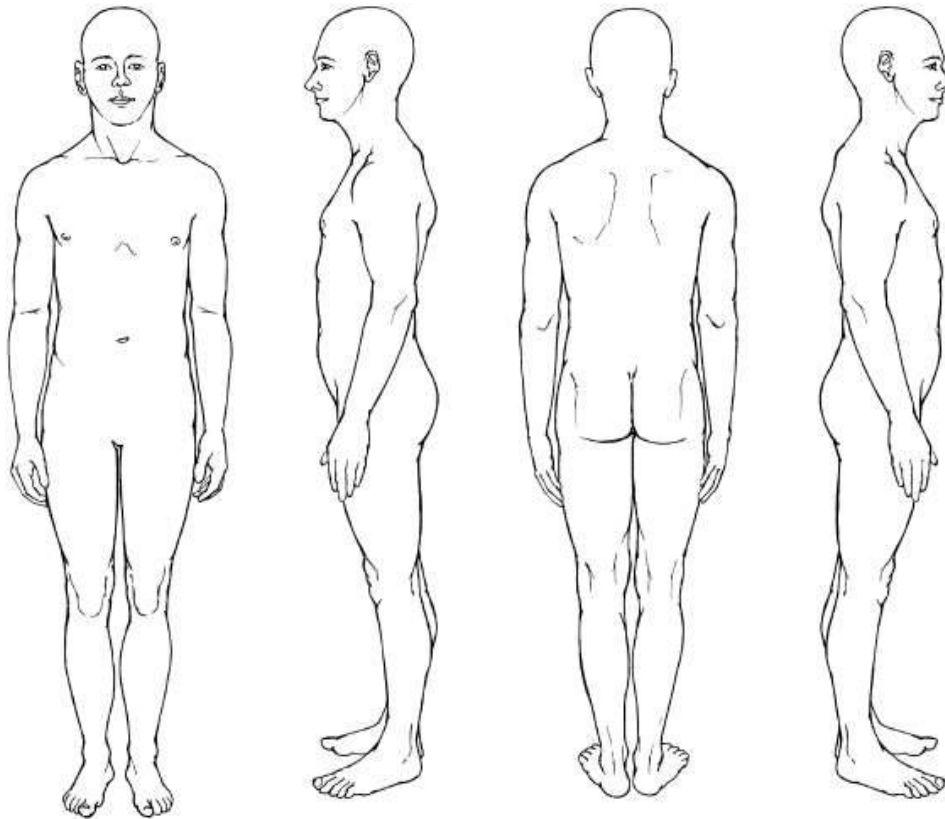
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Are You Pregnant?     Yes     No

# ACUPUNCTURE & BODYWORK CLINIC

This page will help us to understand your pain. If you are not experiencing any pain, it is not necessary to fill out.

Use circles or X's to indicate where you are experiencing symptoms.



Identify the overall intensity of your pain.

Circle the number that best correlates with your pain.

No Pain    0    1    2    3    4    5    6    7    8    9    10

Extreme Pain

Try to explain your pain using descriptive words. How does it feel?

(Examples: Dull-Burning-Sharp-Stabbing-Achy-Catching-Numbness-Tingling-Stiffness-Tightness)

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## Massage Consent Form

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent. I give my permission to share information regarding my therapeutic massage treatment with my health care provider.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_