Benjamin Brooke, LMT, MA

Massage Client Intake Form (Male)

Name: _____ **Date:** _____ **Referred By:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Phone: (H) (_____)_____ (W) (_____)_____ Cell (_____)_____

Occupation: _____ **Date of Birth:** _____ **Email:** _____

Primary Health Care Provider: _____ **Phone: (_____)_____**

Other Current Health Care Provider _____ **Phone (_____)_____**

In Case of Emergency Contact: _____ **Phone: (_____)_____**

Health History

Please note all conditions that you have had **OR** are currently experiencing, and give approximate dates when you had the conditions. Where appropriate, specify the nature of the condition, and where in your body the condition exists or existed.

Have you had any injuries or complaints involving **Musculoskeletal &/Or Nervous Systems**, such as muscle strains or sprains, arthritis, broken bones, head or neck pains, spinal or disc injuries, nerve pain or numbness, etc? if so, please explain:

Have you had any **Cardiovascular or Lymphatic** issues, such as high blood pressure, blood clots, heart trouble or irregular heartbeat, or lymphedema or lymph nodes removed? If so, please explain:

Do you have any current **Skin Conditions**, such as rashes, dermatitis, fungal infections (eg. athletes foot, etc), lice, scabies or parasitic infections, cuts, sores, warts, herpes outbreaks, etc.? If So, please explain:

Do you have any **Other Health Issues** or concerns, such as a cold, flu, or other illness, cancer or tumors, auto-immune disorders, allergies, psychological conditions, sleep or fatigue problems, etc.? If so, please explain:

Accidents & Injuries: Please list all previous accidents & injuries, including dates and treatment received:

Surgeries & Hospitalizations: Please list all surgeries and hospitalizations. Include dates, reasons, and outcomes:

Exercise: How often do you exercise and in what ways?

Please list all current **Medications**, including pain relievers and allergy medicines, and reason for each medication:

Current Massage Treatment Information

Have you received massage before? ___ Yes. ___ No. How often? _____ Date of last massage: _____

(1) What are the symptoms you are currently experiencing, where do they occur in your body, and how severe are they (mild, moderate, or severe) ? What daily activities are affected/limited by the current condition? How are they affected?

(2) When (what date) and how did your current complaint begin?

(3) What results do you hope to get from massage therapy?

(4) What other treatment or therapy have you received for this condition? What other treatments or therapies are you currently receiving?

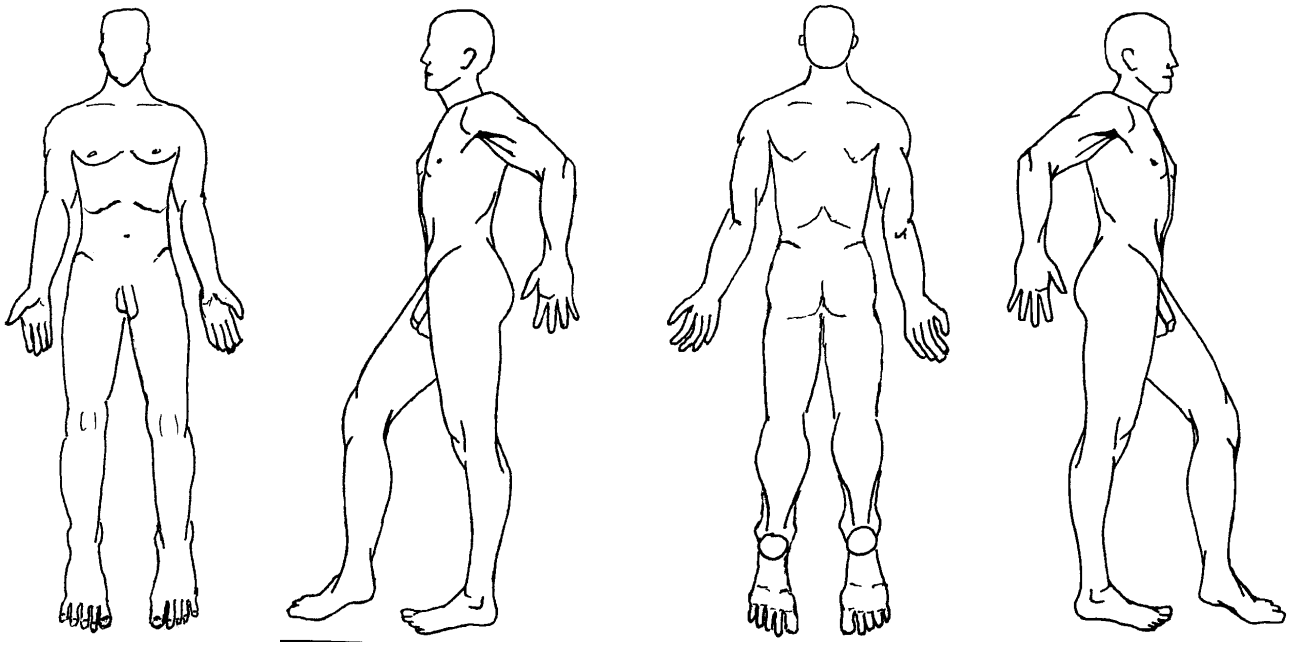
Draw your symptoms on the figure below, using the following symbols:

◯ circle areas of **Pain.**

✕ "X" areas of **joint or muscle Stiffness**

draw a squiggly line for **Numbness** or **Tingling**

hash-mark **Scars, Wounds, Bruises,** or **Serious Burns**



Front Left Side Back Right Side

It is my choice to receive massage therapy. I understand that massage is a direct manual treatment of the body, which can promote both physical and mental health and well-being. I understand that massage therapists do not diagnose illness, disease, or physical or mental disorder; nor do they prescribe medical treatment, exercise, or pharmaceuticals; nor do they perform spinal thrust manipulation or surgery. I understand that massage therapy is not a substitute for medical examination, diagnosis, or prescriptions; and I acknowledge that it is recommended I go to an appropriately licensed health care provider should I require such services. I have read and understand the Statement of Policies for this massage practice, and I agree to abide by these policies. I understand that I am fully responsible for payment for massage treatment at the time services are rendered unless other prior arrangements have been made.

I acknowledge that the information given here is complete and accurate to the best of my knowledge. I agree to update my massage therapist of any changes in my health status.

Client Signature: _____ Date: _____

If Client is under 18 years of age:

Signature of Parent or Legal Guardian: _____ Date: _____