Silver Leaf Massage

Intake Form

Please fill out all information as accurately and thoroughly as possible.
The following information will be used to help plan safe and effective massage sessions.

Date:____________

Name (Printed):______________________________ Date of Birth:____________________

Home Phone:___________________________ Work Phone:__________________________

Cell Phone:_____________________________

Address:____

City:_____________________________ State:__________ Zip:_______________________

E-mail Address:____

Occupation:____

Hobbies:____

Emergency Contact (and their relationship to you):___________________________________

Phone:___________________________

And are you currently under medical supervision? ( )Yes ( )No

If yes, please explain:____

Chiropractor and how often you go:____

How do you relieve stress or pain?____

What are the reasons for your visit today?____

List any reason you are taking medication for : ________________________________

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Do you have any allergies?____

____

Do you exercise? ( )Yes ( )No
Please describe what type of exercise and how often: ________________________________

____

Is it okay to work on: ( )All
( )Head ( )Face ( )Pecs ( )Abdomen ( )Legs ( )Feet ( )Arms ( )Back ( )Glutes

You prefer pressure that is: ( )Light ( )Moderate ( )Moderate/Firm ( )Firm

Use C for current and P for past. Mark any or all that apply.

___ Arthritis	___ Back Problems	___ Blood Clots
___ Blood Pressure High	___ Bruise Easily	___ Chronic Pain
___ Blood Pressure Low	___ Diabetes	___ Fatigue
___ Circulatory Problems	___ Headaches	___ Heart Problems
___ Pregnant	___ Scoliosis	___ Sinus Problems
___ Skin Problems	___ Sprains/strains	___ Tendonitis
___ Teeth Grinding	___ TMJ	___ Varicose Veins
___ Whiplash		

Have you had broken bones or dislocations? ( )Yes ( )No
Do you have ( )Numbness or ( )Stabbing pains anywhere?__________________
If yes, please list, include year:____

____
____

List all surgeries and when:____

____

List all accidents you have had, and when:_____________________________________

____

Do you have a history of cancer?:____

Do you have any other medical conditions?_____________________________________

____

Have you ever had a professional massage before? ( )Yes ( )No
If yes, when/how often:____

Trust your body to express what it needs to do: Moving, Changing Positions, Sighing, Yawning, Change In Breathing, Stomach Gurgling, Emotional Feelings, Energy Shifts, Falling Asleep and/or Memories.

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduces muscular tension, it is not a substitute for medical examination, diagnosis and treatment.

2. As massage can not be done safely under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully. I will keep my practitioner informed of any changes.

Patient Signature:____ Date:__________

How did you hear of us? ____

For each person referred you will receive a coupon for $10 off your next massage.

Consent for Treatment of a Minor: By my signature below, I hereby authorize **Silver Leaf Massage Therapy** to massage my child or dependent as they deem necessary.

Parent or Guardian:_______________________________________ Date:__________

X Areas to avoid. O Areas to focus on.