

Marianne Sears, LMP
MASSAGE INTAKE FORM

Name _____

Date _____

Address _____

Date of Birth _____

Age _____

Home Phone _____

Work/Cell Phone _____

E-mail _____

Occupation _____

What is the main reason for this visit?

Have you received massage before?

Are you currently receiving any medical or chiropractic treatment?

Name of practitioner:

Please list any medications taken at regular intervals:

Do you currently (mark with a C) or have you in the past (mark with a P) experienced to a significant degree any of the following conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> drug/alcohol/caffeine abuse | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> athlete's foot | <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> headaches | <input type="checkbox"/> stiff joints |
| <input type="checkbox"/> back pain/problems | <input type="checkbox"/> heart attacks or ailments | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> hemophilia | <input type="checkbox"/> strains/sprains |
| <input type="checkbox"/> bursitis | <input type="checkbox"/> herpes virus | <input type="checkbox"/> excess stress/anxiety |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> tendonitis |
| <input type="checkbox"/> circulation problems | <input type="checkbox"/> H.I.V. positive | <input type="checkbox"/> tingling/numbness/nerve |
| <input type="checkbox"/> constipation | <input type="checkbox"/> insomnia | <input type="checkbox"/> problems |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> kidney/bladder ailment | <input type="checkbox"/> thrombosis/embolism |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> menstrual problems | <input type="checkbox"/> varicose veins/phlebitis |
| <input type="checkbox"/> digestive problems | <input type="checkbox"/> muscle spasms | <input type="checkbox"/> whiplash |

Please list major illnesses, surgeries or hospitalizations and any past injuries still affecting you.

Are you currently experiencing any of the following conditions?

___ pregnancy

___ localized infection

___ flu or cold

___ inflammation

___ wearing contact lenses

___ communicable illness

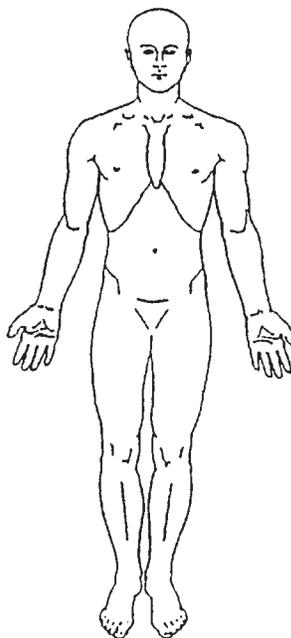
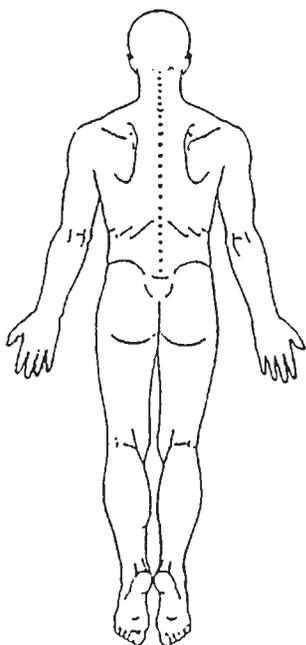
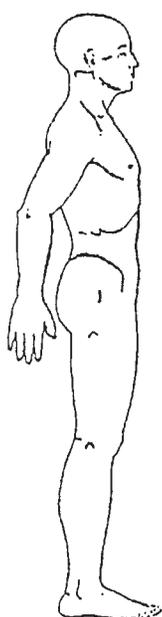
___ fever

Are there any areas of your body that you have special sensitivities about or dislike having touched?

Any areas you especially like worked on?

Where do you tend to hold tension?

On the figures below, please indicate areas of pain or discomfort.



The above information is complete and accurate to the best of my knowledge. I agree to pay for my massages at the time of treatment unless other arrangements have been made. I understand that I may be charged for any appointment broken with less than 24 hours prior notice. I agree to the release of information for medical or insurance purposes. I authorize Marianne Sears, LMP, to obtain information from my primary health care providers concerning my health.

Signature _____ Date _____