Sandra M. Dean, LMP, Reiki Master
Therapeutic Massage • (206) 524-3614
9500 Roosevelt Way NE, Suite 201 • Seattle, WA 98115

MASSAGE INTAKE FORM

NAME ______________________________ DATE ____/____/____

ADDRESS ______________________________

CITY ______________________________ STATE ______ ZIP ____________

PHONE (day) ______________ (evening) ______________ AGE ______ D.O.B. ____/____/____

E-MAIL ______________________________

OCCUPATION ______________________ SSN ________-______-________ SEX ______

Why have you come for a massage? ______________________________

Have you received massage before? ________Comments ______________________________

Accidents, injuries or surgeries…
MORE than 5 years ago ______________________________

LESS than 5 years ago______________________________

Are you receiving any kind of medical treatment? ___ Yes ___No If yes, please explain ______________________________

____

Are you taking any medication? ___ Yes ___ No If yes, please explain ______________________________

____

Have you experienced any of the following conditions? (check all that apply)

Past	Present	
____	____	AIDS or HIV
____	____	Allergies
____	____	Anemia
____	____	Arthritis
____	____	Back pain
____	____	Broken bones
____	____	Bursitis
____	____	Cancer
____	____	Circulation problems
____	____	Diabetes
____	____	Digestive problems
____	____	Disc problems
____	____	Epilepsy/Seizures
____	____	Excema
____	____	Headaches

Past	Present	
____	____	Heart attack or ailments
____	____	Hemophilia
____	____	High blood pressure
____	____	Insomnia
____	____	Low blood pressure
____	____	Migraines
____	____	Muscle spasms
____	____	Numbness
____	____	Phlebitis
____	____	Psoriasis
____	____	Rashes
____	____	Sciatica
____	____	Stiff joints
____	____	Skin allergies
____	____	Strains/Sprains

Past	Present	
____	____	Excess stress
____	____	Stroke
____	____	Swollen feet/legs
____	____	Tendonitis
____	____	Tingling
____	____	Varicose veins
____	____	Whiplash

For women only

Past	Present	
____	____	Menstrual cramps
____	____	Excessive bleeding
____	____	Lack of periods
____	____	PMS

COMMENTS ______________________________

____

____

OVER PLEASE

Are you currently experiencing any of the following conditions? (check all that apply)

___ Pregnancy	___ Flu or Cold	___ Infection
___ Inflammation	___ Fever	___ Contagious disease

If yes, please explain ______________________________

____

____

Are you currently experiencing sleep difficulties? ___ Yes ___ No If yes, please explain ______________________________

____

Do you wear contact lenses? ___ Yes ___ No

PHYSICAL ACTIVITY

___ Heavy ___ Medium ___ Light

Do you work on a computer? ___ Yes ___ No If yes, how many hours per day? ___ How many days per week? ___

How often do you exercise? ______________________________ What kind? ______________________________

____

Where do you tend to hold stress in your body? ______________________________

____

Do you have any especially tender-to-touch areas? ___ Yes ___ No If yes, please explain ______________________________

____

EMERGENCY CONTACT: ______________________________ **PHONE:** ______________________________

PLEASE READ AND SIGN THE FOLLOWING:

I acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information for medical or insurance purposes. I authorize Sandra M. Dean, LMP, Reiki Master to obtain any formation from my primary health care providers concerning my health. I clearly understand that my massage therapy treatments are my personal financial responsibility, and I agree to pay for these services at the time of treatment, unless other arrangments have been made. I also understand that I will be charged for any appointments not kept without giving at least 24 hours notice.

______________________________ ______/______/______

Patient Signature Date