Andrew Vogel, LMT - Therapeutic Massage
Confidential Client Intake Form

Name:_____

Address:_____ City/State/Zip:_____

E-Mail:_____ Occupation:_____

_____ Please check if you'd like to receive occasional massage therapy newsletters, special offers and programs!

Day Phone: (_____)_____Eve. Phone: (___ _)_____Cell Phone: (__ __)_____

Birth Date: _____/_____/_____ Height: _____ Weight:_____

Emergency Contact: _____ Phone: (_____)_____

Have you ever received a professional massage? No_____ Yes_____ Date of Last Massage: _____
What results do you want from your massage?_____
Are you currently seeing a medical practitioner? No_____ Yes_____ If Yes, Please explain: _____
_____
List current medications, including aspirin, ibuprofen, herbs, supplements, etc.: _____
_____
_____
List exercise and stress reduction activities, and how often you do them: _____
_____

MEDICAL HISTORY:

Medical Allergies:_____ Skin allergies or sensitivities:_____
Accidents/Injuries/Surgeries: (include year): _____
_____
_____
Major Illnesses: _____
_____
Please check if you are wearing:
Contacts: _____ Dentures:_____ Transdermal patch (i.e.- nicotine, pain, hormone patches) _____
Do you have an IV port: _____

Having a complete medical history is important for the assessment process and in determination of your customized massage plan. In each of the following sections, please mark "past" and /or "Current" next to any items that apply to your health history.

MUSCULOSKELETAL SYSTEM

	Past	Current
bone or joint disease	_____	_____
tendonitis or bursitis	_____	_____
broken bones	_____	_____
arthritis	_____	_____
sprains / strains	_____	_____
spasms / cramps	_____	_____
jaw pain	_____	_____

	Past	Current
neck pain	_____	_____
upper back / shoulder pain	_____	_____
arm pain	_____	_____
mid back pain	_____	_____
low back pain	_____	_____
hip and/or leg pain	_____	_____

other (please explain): _____
_____

CIRCULATORY SYSTEM

	Past	Current
heart conditions	_____	_____
varicose veins	_____	_____
high blood pressure	_____	_____
low blood pressure	_____	_____
blood clots	_____	_____
lymphedema	_____	_____

other: _____

SKIN

	Past	Current
allergies	_____	_____
rashes	_____	_____
athlete's foot	_____	_____
warts	_____	_____

other:_____

NERVOUS SYSTEM

	Past	Current
numbness / tingling	_____	_____
chronic pain	_____	_____
herpes / shingles	_____	_____
fatigue	_____	_____
sleep disorders	_____	_____

other: _____

DIGENSTIVE / URINARY SYSTEM

	Past	Current
constipation	_____	_____
gas / bloating	_____	_____
diverticulitis	_____	_____
irritable bowel syndrome	_____	_____
kidney / bladder problem	_____	_____

other: _____

RESPIRATORY SYSTEM

	Past	Current
breathing difficulties	_____	_____
sinus problems	_____	_____
allergies	_____	_____

other: _____

REPRODUCTIVE SYSTEM

	Past	Current
bloating	_____	_____
abdominal cramps / pain	_____	_____
mood swings	_____	_____
breast tenderness	_____	_____

other: _____

MENSTRUAL CYCLE

	Past	Current
PMS	_____	_____
painful periods	_____	_____
irregular or absent periods	_____	_____
pregnancy – if yes, #of wks	_____	_____
pre–or menopausal symptoms	_____	_____

other: _____

OTHER

	Past	Current
headaches	_____	_____
cancer / tumors	_____	_____
diabetes	_____	_____
thyroid disorder	_____	_____
eating disorder	_____	_____
depression	_____	_____
drug / alcohol addiction	_____	_____
nicotine / caffeine addiction	_____	_____
hearing loss	_____	_____

other: _____

It is my choice to receive massage therapy. I realize that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. I agree to communicate with my therapist. If I experience any 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 understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status. The practitioner reserves the right to refuse services for reasons of safety of the client. It is also understood that any illicit or sexually suggestive remark or advance made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

It is appreciated that if you can't keep an appointment, please let the practitioner know as soon as possible. If you do not show up for three appointments without calling, you will be required to pre-pay should you wish to reschedule.

SIGNATURE: _____ DATE: _____