



acupuncturekitchen

Massage Intake

Name: _____ Date of Birth: _____
 Address: _____ Referred by: _____
 Phone: _____ Email: _____

Height _____ Weight _____

Have you ever had a massage? **YES NO**

Preferred massage pressure: **DEEP MEDIUM LIGHT**

Are you under the care of a health provider?
 If so, please describe.

Do you exercise or participate in sports? If so,
 which ones?

Have you recently suffered an acute injury or
 have areas or inflammation?

History of accidents:

Have you had any surgery? If yes, explain:

Do you have any medical conditions:

Current medications/vitamins:

Do you have any allergies?

Are you pregnant: **YES NO**

Are you wearing a IUD: **YES NO**

Do you have a known leg length discrepancy?
YES NO

Which leg is longer? **RIGHT LEFT**

How many inches?

Health History: *please check*

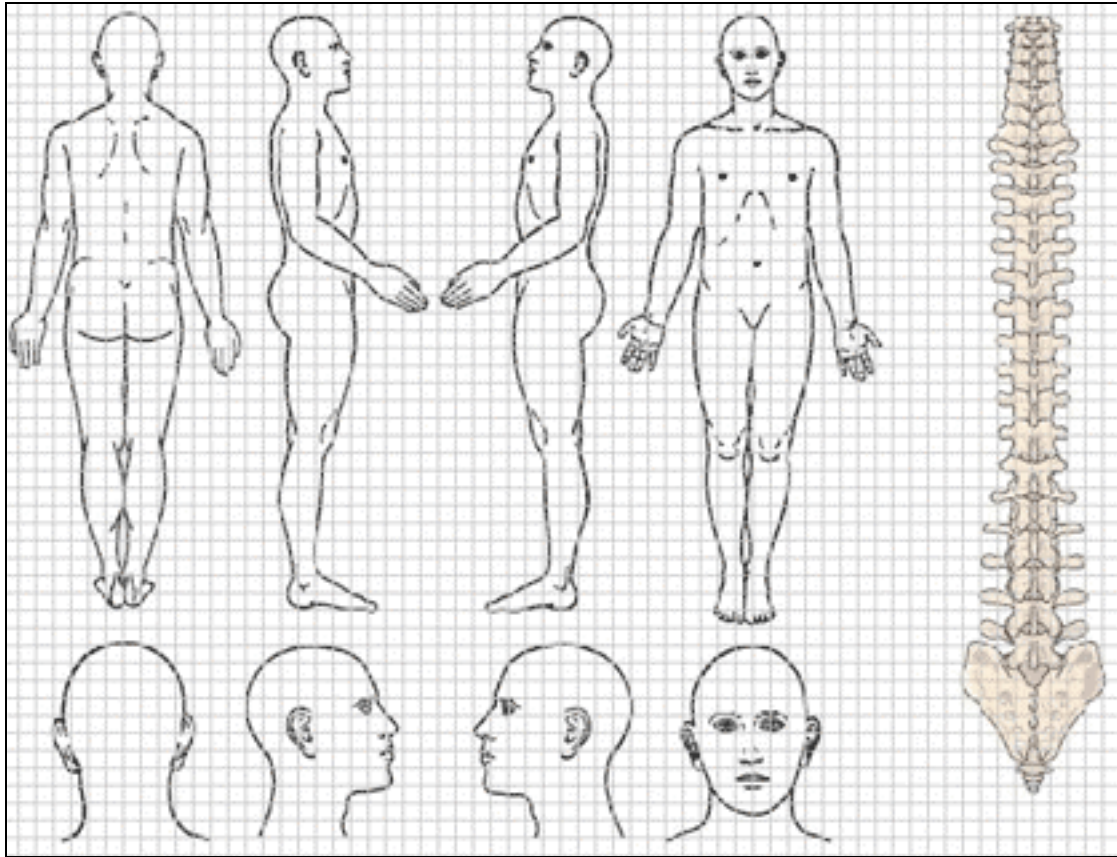
	YES	NO
Contact Lenses		
Dentures		
Back pain / Sciatica		
Osteoporosis / Broken Bones		
Easy Bruising		
Skin Problems		
Headaches / Migraines		
TMJ Syndrome		
Allergies / Asthma		
Varicose Veins		
Phlebitis / Blood Clots		
Heart Problems		
High/Low Blood Pressure		
Ulcer		
Tendonitis, Bursitis, etc.		
Arthritis		
Diabetes		
Seizure, Convulsions		
Multiple Sclerosis		
Cancer or Tumors		
Venereal Disease / Herpes		
Infections/Communicable Diseases		

Goals: Please list three goals that you would like to accomplish with receiving massage?

- 1 _____
- 2 _____
- 3 _____

I understand that this spa treatment is not a replacement for medical care and no diagnosis will be made. Please notify us of any changes in the above information during future visits. Parent/guardian must sign and give consent for guests 17 and under.

SIGNATURE **DATE**



Please indicate problem areas on the above diagram. You will have an opportunity to discuss specific issues with your massage therapist before you begin your treatment session.

Anything else you'd like to tell us?
