



Massage Intake Form

(please print)

First & Last Name Today's Date

Street Address City State Zip

Phone Number Email Address Ht Wt Sex Age Date of Birth

Your Occupation/Employer Emergency Contact (Name & Phone Number)

Primary Care Physician (Name, Practice, Location)

OB/GYN or Urologist (Name, Practice, Location)

Reproductive Endocrinologist (Name, Practice, Location)

How did you hear about us? (doctor, nurse, friend, website, flyer)

In case of a Press Event, would you be willing to share your story? Yes No

If YES, please check which of the following we could contact you about:

- Print/Interview TV Radio Testimonial

Health History

What are the health problems for which you are seeking treatment?

How long have you had this condition?

What other forms of treatment have you sought?

Please list any surgeries or major health incidents (year and type)

Please summarize your daily diet

Family Medical History

Please list the types of massage you've experienced _____

Present Symptoms:

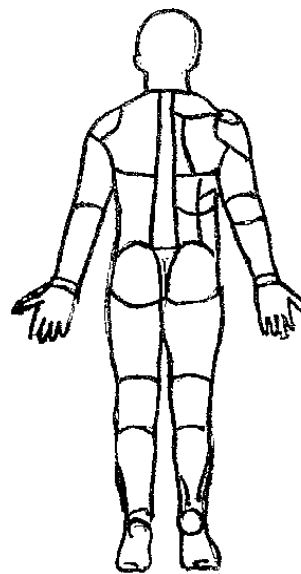
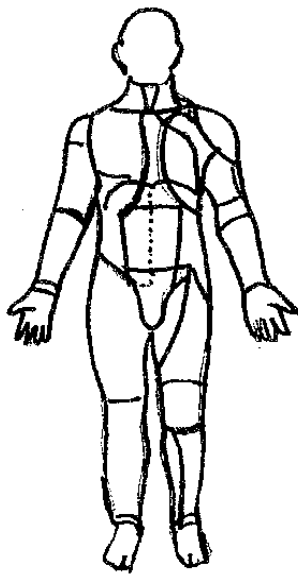
Please mark areas of complaint on the figures below, and check the appropriate symptom.

Sensation: Pain Tingling Numbness Other

Level: Mild Moderate Severe

Frequency: Constant Intermittent

Status: Improving Getting worse No change



Does this affect your:

Sleep: Yes No

Work: Yes No

Daily activities: Yes No If Yes, please list _____

Additional comments _____

Please list the exercise activities you engage in:

Activity _____ Duration _____ mins. Frequency _____ x/week

Activity _____ Duration _____ mins. Frequency _____ x/week

Activity _____ Duration _____ mins. Frequency _____ x/week

General Information

Are you currently receiving medical treatment? Yes No

If Yes, for what condition? _____

Are you pregnant? Yes No If Yes, when is your due date? _____

Please list any current medications _____

Please indicate if you have had conditions affecting the following systems of the body.

Current Past

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory (i.e. blood clots, heart problems, varicose veins, stroke, poor circulation, high/low blood pressure) |
| <input type="checkbox"/> | <input type="checkbox"/> | Digestive (Le. abdominal pain, bowel dysfunction, gastric reflux) |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine (i.e. diabetes, hyper/hypo-thyroid) |
| <input type="checkbox"/> | <input type="checkbox"/> | Reproductive (i.e. endometriosis, pelvic inflammatory disease, prostatitis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory (i.e. allergies, asthma, emphysema, bronchitis) |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin (i.e. recent scars, contagious, wounds/burns, rashes, warts, infections) |
| <input type="checkbox"/> | <input type="checkbox"/> | Skeletal/joint (i.e. osteoporosis, arthritis, scoliosis, disc problems, fracture) |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary (Le. bladder problems, kidney dysfunction) |

Fertility Information

Are you currently undergoing fertility treatment? Yes No

Drug protocol? Yes No

If yes, describe _____

Have you miscarried? Yes No

You may provide an optional synopsis of your fertility history _____

Consent for Care

I understand that my massage sessions at Pulling Down the Moon are for general relaxation, stress reduction, relief from muscular tension, contraction or spasm, increasing circulation, tending to ischemic areas or trigger points, bringing the body back into equilibrium, enhancing reproductive function, and overall well being. I have stated all known medical conditions and understand that it is my responsibility to keep my massage practitioner informed of any changes in my health and medications. I will inform my massage practitioner if I am post ovulation as I may be pregnant, and will be treated as such during the massage. I also understand that massage is not a substitute for medical treatment and that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I further understand that any illicit or sexually suggestive remarks or advances made before or during the scheduled massage session will result in immediate termination of the current therapy session, and I will be liable for payment of the "full" scheduled appointment.

Client's Signature

Date