

Confidential Intake Form

Betsy George, Licensed Massage Therapist

Address City State Zip Phone (h) (w) Occupation Occupation Emergency Contact Emergency phone City Referred by Reason for visit Referred by City City City City Massage History/Treatment Information Referred by City City	Name Date				
Phone (h) (w) Occupation Emergency Contact Emergency phone Reason for visit Referred by Massage History/Treatment Information Have you ever received a professional massage? Date of last massage What results do you want from your massage sessions? Do you have any areas that need special attention? neck/head arms/shoulders low back/hips legs upper back mid-back abdomen feet List any stress reduction and exercise activities. Include frequency:	Address	City	State	Zip	
Emergency Contact	Phone (h) (w)		Occupation		
Reason for visit	Emergency Contact	Emergency phone			
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List any stress reduction and exercise activities. Include frequency:					
	Surgeries?				
	Please check conditions you have:				
Chronic pain Respiratory problems	Chronic pain		Respiratory problems		
Numbness/tingling Circulatory/Heart					
Spinal problems Varicose veins/blood clots					
Headaches/head injuries High/low blood pressure					
	Spasms/cramps		Kidney problems		
	Arthritis, bursitis or tendonitis		Skin problems/allergies		
	Anxiety/Depression		Pregnancy		
	Digestive/gastrointestinal issues		Menstrual problems		
Sleep disorders Infectious disesase	Sleep disorders		Infectious disesase		
Are you currently receiving treatment, including mental health, from a health care professional?	Are you currently receiving treatment in	aluding montal	health from a health cor	a professional?	
	If yes, please give name and location	cituding mental	i nealth, nom a nealth car	e professional?	

I have listed all my known medical conditions and physical limitations and will inform the massage therapist of any change in my physical health. I understand that a massage therapist does not diagnose illness, disease, or any other medical, physical, or emotional disorder. I am responsible for consulting a qualified physician for any physical ailment that I have.

Signature

Date

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