# Massage Intake

YOUNG MD
LASER & MEDICAL AESTHETICS

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip Code: _____

Email: _____ Phone: _____

Emergency Contact Information: _____

## Medical History

The following information will be used to help plan a safe and effective massage session.
Please answer the questions to the best of your knowledge

Have you had a professional massage before? Y/N _____
If yes, how often do you receive a massage? _____

Do you have difficulty lying on your back? Y/N _____
If yes, please explain _____

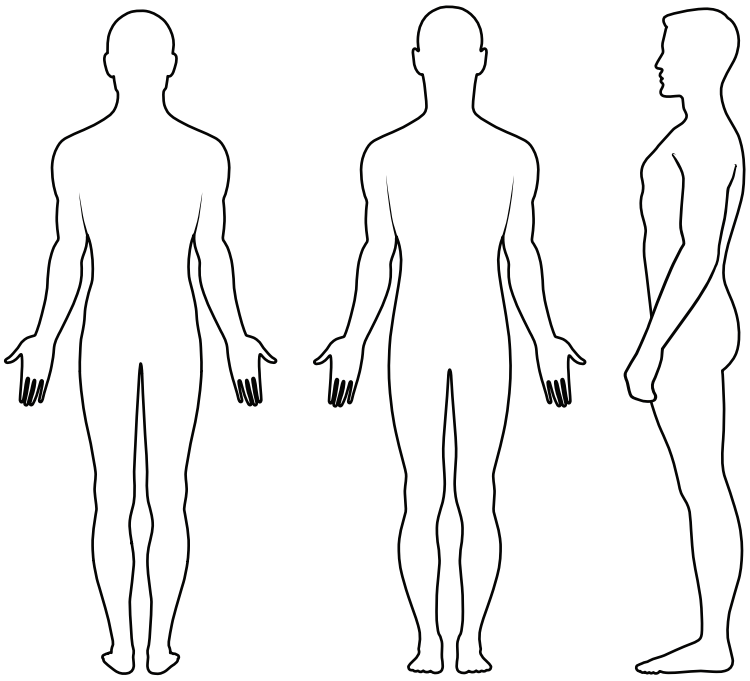
Do you have any allergies to oils, lotions, or ointments? Y/N _____
If yes, please explain _____

Do you have sensitive skin? Y/N _____

Do you sit for long hours at a workstation, computer, or while driving? Y/N _____

Do you have any particular goals in mind for this massage session? Y/N _____
If yes, please explain _____

Please circle specific areas where you are experiencing tension, stiffness, pain, or other discomfort.



# Massage Intake Continued

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Are you currently under medical supervision? Y/N _____
If yes, please explain _____

Do you use a chiropractor? Y/N _____
If yes, please explain _____

Current medications: _____

Please check any conditions below that apply to you:

_____ Contagious skin condition
_____ Open sores or wounds
_____ Easy bruising
_____ Recent accident or injury
_____ Recent fracture
_____ Recent surgery
_____ Artificial joint
_____ Sprains/Strains
_____ Swollen glands
_____ Allergies/Sensitivity
_____ Diabetes
_____ Fibromyalgia
_____ Carpal Tunnel Syndrome

_____ Heart condition
_____ High or low blood pressure
_____ Circulatory disorder
_____ Varicose veins
_____ Deep vein thrombosis/Blood clots
_____ Joint disorder/Rheumatoid Arthritis/Osteoarthritis/Tendinitis
_____ Osteoporosis
_____ Epilepsy
_____ Headaches/Migraines
_____ Cancer
_____ Back/Neck Problems
_____ TMJ
_____ Pregnancy - If yes, how many months? _____

Please explain any conditions that you have marked above _____

_____

_____

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage? _____

_____

The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I understand this does not deter me from seeking medical treatment for medical conditions. I understand that no inappropriate comment or conduct will be tolerated. I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist should I forget to do so.

Signature: _____ Date: _____