Peninsula Health Care District
Health & Fitness Center
1875 Trousdale Drive, Burlingame, CA 94010

Massage Therapy Intake Form

Date of Initial Visit: _____

Name: _____
(LAST) (FIRST) (M.I.)

Date of Birth: _____ ☐ Male ☐Female

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact Info/Relationship: _____

Emergency phone: ( ) _____

☐ **Please check this box to give permission for Center Staff to notify my Emergency Contact if there is an emergency situation.**

Current Status:
How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you currently engage in a structured exercise program? ☐ Yes ☐ No

Do you perform any repetitive movement in your work or hobby? ☐ Yes ☐ No

Have you had a professional massage before? ☐ Yes (Date of last treatment)_____ ☐ No

Are you experiencing tension, stiffness, discomfort, or pain? ☐ Yes ☐ No

If yes, describe: _____

Have you recently had an injury, surgery or areas of inflammation? ☐ Yes ☐ No

If yes, describe:_____

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Do you have sensitive skin: ☐ Yes ☐ No

Do have any allergies to oils, lotions or ointments? ☐ Yes ☐ No

If yes, please describe: _____

List any known allergies other than oils, lotions or ointments: _____

_____

_____

List any medications you are taking and the conditions they are treating: _____

_____

_____

_____

_____

List any major accidents, surgeries or injuries (including dates): _____

_____

_____

Reason for initial visit: _____

_____

_____

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Health History: (check all that apply)

Head/Neck

__ Headaches/migraines
__ Vertigo/dizziness
__ Ringing in ears
__ Vision problems
__ Hearing loss
__ Vision loss

Musculoskeletal

__ Arthritis
__ Family history of arthritis
__ Osteoporosis
__ Tendonitis
__ Bursitis
__ Jaw pain (TMJ)
__ Pins/plates/wires/artificial joints

Respiratory

__ Asthma
__ Shortness of breath
__ Chronic cough
__ Bronchitis
__ Emphysema
__ Sinusitis
__ Frequent colds
__ Smoker
__ Family history of respiratory illness

Nervous System

__ Sensory loss/change
__ Numbness/tingling
__ Sciatica
__ Epilepsy
__ Multiple sclerosis
__ Seizures

Cardiovascular

__ High blood pressure
__ Low blood pressure
__ Heart attack
__ Stroke
__ Heart disease
__ Poor circulation
__ Pacemaker
__ Phlebitis/varicose veins
__ Hemophilia
__ Chronic congestive heart failure
__ Family history of cardiovascular problems

Skin & Infections

__ Hepatitis
__ HIV/AIDS
__ Herpes
__ Tuberculosis
__ Lyme disease
__ Infectious skin conditions

Reproductive

__ Pregnant
__ Given birth
__ Gynecological problems

Other Conditions

__ Cancer
__ Diabetes
__ Unexplained weight loss
__ Digestive conditions
__ Fibromyalgia
__ Chronic fatigue syndrome
__ Depression
__ Anxiety
__ Psychiatric disorder
__ Other _____

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Massage Therapy Waiver

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis.

I have stated all medical conditions that I am aware of and will immediately inform my therapist of any changes in my health status. If I fail to inform my therapist of any medical changes, I understand there shall be no liability on the therapist's part.

I understand that my personal health information will be collected and that all information I provide will be kept confidential.

I understand that any illicit, inappropriate, or sexual comments or advances will result in immediate termination of the massage session, and I will be liable for payment of the scheduled appointment.

I understand that the Peninsula Health Care District has provided this form as a reference and will not be held liable for any services provided.

_____
(Print Name)

_____ _____
(Signature) (Date)