



Client Name _____

Welcome to the practice at Optimum Health Massage Associates. I am so happy you have made a choice to include massage as part of your healthcare and wellness plan. Massage is a healthy complimentary therapy for the body, mind and spirit. We are here to help you achieve your optimum health care goals.

By choosing us as your massage therapy provider you are trusting us to have your wellness goals in mind. Before, during and after a therapeutic session, it is imperative that you discuss any concerns with the therapist so that your therapy is effective and appropriate. If you are experiencing any medical or physical changes please inform the therapist. If you experience pain, tingling, numbness or any unusual sensation, please inform the therapist. It is essential that you have open and honest communication with the therapist so that you may gain the benefits of massage.

Please take a moment to indicate the reason you are seeking therapy:

Pain Relaxation Doctor suggested Doctor prescribed Trainer suggested
 Read about massage Friend referred Moved to area seeking a new therapist
 Wellness for self gift Other

If pain brought you in, where are you experiencing pain?

Have you had massage before? _____ When was the last massage? _____ Did you think it was effective? _____ Why or why not? _____

Do you think massage will be a regular part of your wellness plan? _____

How often do you anticipate having massage therapy? once only about once/month about 2-6 times per year more than 6 times per year until problem resolved don't know

How did you hear about us? friend signs yoga studio chiropractor physician ad
_____ other

Do you have any questions for the therapist? Please write them here:

Optimum Health Massage Associates Client Intake Form

Date: _____

Client Name: _____

Male Female

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Daytime Phone #: _____ Evening Phone #: _____

Date of Birth: _____ Occupation: _____

Single Married

Name of Spouse/Significant Other: _____

Preferred Appointment Day and Time: _____

For Doctor Referral or Insurance Claims:

Employer: _____

Employer's Address: _____

Primary Health Care Provider: _____

Provider's Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Extension: _____

Permission to Consult with Primary Provider? No Yes _____ (please initial if yes)

If client is under age 18, please complete:

Custodial Adult Name: _____

Relationship: _____

Telephone #: _____

Grade in School _____

Activities: _____

Who is responsible for payment? _____

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____

Relationship: _____

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

- Headaches
- Joint stiffness/swelling
- Spasms/cramps
- Broken/fractured bones
- Strains/sprains
- Back, hip pain
- Shoulder, neck, arm, hand pain
- Leg, foot pain
- Chest, ribs, abdominal pain
- Problems walking
- Jaw pain/TMJ
- Tendinitis
- Bursitis
- Arthritis
- Osteoporosis
- Scoliosis
- Bone or joint disease
- Other: _____

Circulatory and Respiratory

- Dizziness
- Shortness of breath
- Fainting
- Cold feet or hands
- Cold sweats
- Swollen ankles
- Pressure sores
- Varicose veins
- Blood clots
- Stroke
- Heart condition
- Allergies
- Sinus problems
- Asthma
- High blood pressure
- Low blood pressure
- Lymphedema
- Other: _____

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Moles
- Acne
- Cosmetic surgery
- Other: _____

Digestive

- Nervous stomach
- Indigestion
- Constipation
- Intestinal gas/bloating
- Diarrhea
- Diverticulitis
- Irritable bowel syndrome
- Crohn's Disease
- Colitis
- Adaptive aids
- Other: _____

Nervous System

- Numbness/tingling
- Twitching of face
- Fatigue
- Chronic pain
- Sleep disorders
- Ulcers
- Paralysis
- Herpes/shingles
- Cerebral Palsy
- Epilepsy
- Chronic Fatigue Syndrome
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's disease
- Spinal cord injury
- Other: _____

Reproductive System

- Pregnancy:
 - Current
 - Previous
- PMS
- Menopause
- Pelvic Inflammatory Disease
- Endometriosis
- Hysterectomy
- Fertility concerns
- Prostate problems

Other

- Loss of appetite
- Forgetfulness
- Confusion
- Depression
- Difficulty concentrating
- Drug use _____
- Alcohol use _____
- Nicotine use _____
- Caffeine use _____
- Hearing impaired
- Visually impaired
- Burning upon urination
- Bladder infection
- Eating disorder
- Diabetes
- Fibromyalgia
- Post/Polio Syndrome
- Cancer
- Infectious disease (please list)

- Other congenital or acquired disabilities (please list) _____
- Surgeries _____
- Other: _____

For clients who need mobility assistance, please give your height: _____ weight: _____

Please list any additional comments regarding your health and well-being: _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by Optimum Health Massage Associates is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

I have received a copy of the therapist's policies, I understand them and agree to abide by them.

Client Signature

Date