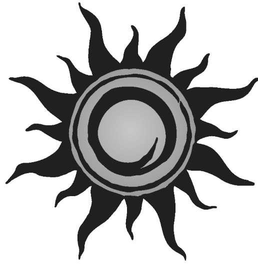

# The Massage Collective

*Boulder Massage & NeuroMuscular Therapy*

## Intake and Health History Form

All health and personal information is kept strictly confidential and will not be released except with your written consent or legal subpoena.

Name: ____________________________________________Date: _______________

Address: __________________________________________Occupation:___________________

City:___________________ State:______________ Zip:___________Birth Date: _____________

Telephone #:____________________________Alternative #:_____________________________

E-mail address: ___________________________________________________________________

Yes/No Include you on Boulder Massage e-mail list?

Emergency Contact and #: _____________________________________________________

Referred by/How did you hear about us? __________________________________________

~ Please take a moment to read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. ~

Please indicate areas of issue with pain scale of 1 – 10
1= mild discomfort 10 = extreme discomfort

- Hands ______
- Elbows ______
- Arms ______
- Shoulder ______
- Feet ______
- Ankles ______
- Knees ______
- Spasm/Cramps ______
- Sciatica ______
- Whiplash ______
- Numbness or tingling in extremities ______
- Low back ______
- Neck ______
- TMJ (jaw pain) ______
- Headaches ______
- Sprains/ Fractures/ Dislocations ______
- Circulation ______
- Bruising ______
- Osteoarthritis ______
- Rheumatoid Arthritis______
- Asthma ______
- Allergies ______
- Digestive problems ___
- Menstrual pain ______
- Scoliosis______
- Tendonitis _____
- Bursitis _____
- Other –Please Specify ____________________________________

- Please indicate if you suffer from any of the following conditions:

- Angina/Heart condition
- Hardening of the arteries
- High blood pressure
- Low blood pressure
- Stroke
- Varicose veins
- Cancer
- Diabetes
- DVT/blood clots
- Cerebral Palsy
- Epilepsy/ seizures
- Muscular Dystrophy
- Multiple Sclerosis
- Fibromyalgia
- Skin problems
- Infectious disease
- Depression
- Lymph edema
- Parkinson's
- Recurrent infections

(See second page)

Main Complaint/Reason for seeking massage therapy: ___________________________________________

_____________________________________________________________________________________________

Are you currently seeing a medical professional for this condition? Yes/No

If Yes, Who? _______________________________________

Current medications related to main complaint (specifically pain medication and muscle relaxants)

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Significant injuries, surgeries or motor vehicle accidents?_____________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

What are your health care goals?_________________________________________________________________

How many hours a week do you spend on the computer? _____ Laptop? ______ Desktop? ________

Have you experienced professional massage or bodywork? Yes/No

Have you experienced the benefits of receiving regular massage treatments? Yes/No

If Yes, When? ________________ What frequency? ______________ (1 x Week, Month, etc)

Reason for discontinuing? _______________________________________________________________

What physical activities do you participate in? ____________________________________________________

_____________________________________________________________________________________________

What are your fitness goals? _____________________________________________________________________

Research has shown that the benefits of massage therapy are multiplied with regularity.
Would you like to reap the many rewards of receiving regular massage therapy? Yes/No

If Yes, How can we help you make that your reality? _______________________________________

_____________________________________________________________________________________________

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I understand that bodywork is not a substitute for medical treatment or medications. Because bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep my practitioner updated as to any changes in my medical profile.

If I experience any pain or discomfort during a session, I will immediately inform my practitioner so that appropriate adjustments can be made.

I also understand that inappropriate behavior will result in immediate termination of the session, and I will be liable for payment, in full, of the appointment.

I agree that Boulder Massage Therapists may telephone me for appointment follow-ups to ensure I get the best possible care.

Finally, I understand that there is a 24 hr. minimum notice required for cancellations and that I am responsible for payment if I "no show" or do not provide adequate notice.

Client Signature: _____________________________________________________Date:___________

Parent/Guardian Consent:_______________________________________________Date:___________