Massage Therapy Intake and Consent Form

Name:__________________________ Age:_____ Date:______________
Address:____
Phone: H:________________ Wk:_______________ Cell:_______________
E-mail:___________________________ Occupation:_____________________
Medical Doctor:________________________ Referred by:______________
Date of Birth:______________________

Health Benefits Insurance Company:__________________________________
Policy #_________________________ ID#:____________________________

Chief Health Concerns:
1/____
2/____
3/____

Date and cause of Injury (if applicable):_________________________________
X-rays/MRIs performed? Y/N

Any referral pain: Y/N ______________________________
Pain: Intensity out of 10 (worst is 10):_______
What makes it worse:____
What makes it better:____
Sleep affected: Y/N

Current Medications:____
Natural Supplements:____

Other Health Concerns: circle or list any relevant health issues
Cardiovascular (high/low BP, varicose veins, past heart attack or stroke, pacemaker) ____
Respiratory (chronic cough, bronchitis, asthma, COPD) ____________________
Neurological (MS, Parkinsons) ____
Muscle/Joint (OA, RA, Fibromyalgia) ____________________________________
Gastrointestinal (Crohns, Ulc. Colitis, GERD) ____________________________
Other: (Headaches/Migraines, Allergies, Cancer, Epilepsy, Skin conditions)
____

Pregnant: Y/N How many weeks? ______

I, _______________________________ consent to the treatment of massage therapy by a registered massage therapist at Hawthorn Clinic.

Patient signature: _________________________ Date: _________________
Witness signature: ________________________ Date: _________________