Raya Wellness

Massage Therapy Intake Form

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Contact Information

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Country _____

Phone (Work) _____ Phone (Home) _____ Phone (Mobile) _____

Email _____ Date of Birth _____

Occupation _____ Referred by _____

Health Information

Have you received massage therapy before? ❑ Yes ❑ No If yes, what type(s)? _____

_____

List current medications, including ibuprofen, herbs, and supplements: _____

_____

_____

List regular physical activities: _____

_____

_____

Have you ever had any of these? (Please place a check by any that pertain to you)

❑ Accident	❑ Sprains	❑ Varicose veins
❑ Neck pain	❑ Seizures	❑ Diabetes
❑ Whiplash	❑ Headaches	❑ Allergies to nuts
❑ Abdominal pain	❑ High blood pressure	❑ Currently pregnant
❑ Disc problem	❑ Nervous tension	❑ Stroke
❑ Mid back problems	❑ Arthritis, bursitis or gout	❑ Heart attack
❑ Low back problems	❑ Allergies to oils or perfumes	❑ Cancer

❑ Joint ache ❑ Wear contacts or other prosthesis ❑ Colitis

❑ Decreased range of motion ❑ Surgery ❑ HIV

❑ Broken Bones ❑ Breast augmentation ❑ Inflammation

❑ Severe pain ❑ Sciatica ❑ Irritated skin rash

❑ Others, explain _____

_____

_____

Please indicate your average consumption of the following:

Water _____cups/day

Caffeine _____cups/day

Alcohol _____drinks/week

Have you consumed alchohol in the past 24 hours? ❑ Yes ❑ No

PLEASE READ THE FOLLOWING AND SIGN BELOW BELOW:

I UNDERSTAND THAT MASSAGE THERAPY IS NOT A REPLACEMENT FOR MEDICAL CARE AND THAT NO DIAGNOSIS WILL BE MADE. I AM RESPONSIBLE FOR PAYING FOR ANY APPOINTMENT CANCELLATION OF LESS THAN 24 HOURS.

Date_____

Signature _____

In order to make your experience more enjoyable, be an active participant in the session. Ask questions about things you don't understand, make your wishes known, and let me know if you are uncomfortable at any time. Above all, relax and enjoy your massage!

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