

Solace Spirit Massage Intake Form

Personal Information

Name: _____
Address: _____ City/State/Zip: _____
Home phone: _____ Cell phone: _____ Work phone: _____
Email: _____ Referred by: _____
Date of birth: _____ Marital status: _____
Occupation: _____ Employer: _____
Primary Physician: _____
Emergency Contact: _____ Phone: _____

Medical Information

What is your major complaint? _____

When did you first notice this? _____

What brought it on? _____

What makes it worse? _____

Is this condition getting progressively worse?
 yes no constant comes and goes

Is this condition interfering with your:
 work sleep daily routine

What have you done to get relief? _____

Are you taking any medications? yes no
If yes, please list: _____

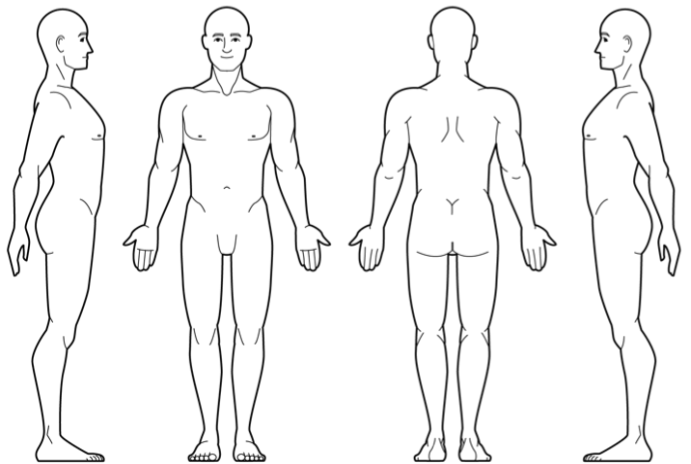
Has there been a medical diagnosis? yes no
If yes, what was the diagnosis? _____

Massage Information

Are there areas (feet, face, abdomen, etc.) you do not want massaged? yes no
Please explain: _____

What are your goals for this treatment session?

Please circle any areas of discomfort:



Miscellaneous Information

Age of mattress: _____
 Comfortable Uncomfortable
Do you use a foam pillow? yes no
Do you sleep on: side back stomach
Are you wearing:
 heel lifts inner soles arch supports sole lifts

Health History

<p>Musculoskeletal</p> <p><input type="checkbox"/> Bone or joint disease</p> <p><input type="checkbox"/> Tendonitis/Bursitis</p> <p><input type="checkbox"/> Arthritis/Gout</p> <p><input type="checkbox"/> Jaw pain (TMJ)</p> <p><input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> Spinal problems</p> <p><input type="checkbox"/> Headaches/migraines</p> <p><input type="checkbox"/> Osteoporosis</p> <p><input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Spains or strains</p> <p><input type="checkbox"/> Plantar fasciitis</p> <p>Circulatory</p> <p><input type="checkbox"/> Heart condition</p> <p><input type="checkbox"/> Phlebitis/varicose veins</p> <p><input type="checkbox"/> Blood clots</p> <p><input type="checkbox"/> High/low blood pressure</p> <p><input type="checkbox"/> Lymphedema</p> <p><input type="checkbox"/> Thrombosis/embolism</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Cold hands/feet</p> <p><input type="checkbox"/> Dizziness/fainting</p>	<p>Respiratory</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Breathing difficulty</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Allergies, specify: _____</p> <p><input type="checkbox"/> Sinus problems</p> <p>Nervous System</p> <p><input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> Numbness/tingling</p> <p><input type="checkbox"/> Pinched nerve</p> <p><input type="checkbox"/> Chronic pain</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Pins & needles in arms/ hands/legs</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Parkinson's Disease</p> <p>Vision/Hearing</p> <p><input type="checkbox"/> Light bothers eyes</p> <p><input type="checkbox"/> Ringing in ears</p>	<p>Skin</p> <p><input type="checkbox"/> Allergies, specify: _____</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Cosmetic surgery</p> <p><input type="checkbox"/> Athlete's foot</p> <p><input type="checkbox"/> Herpes/cold sores</p> <p>Digestive</p> <p><input type="checkbox"/> Irritable bowel syndrome</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Bladder/kidney</p> <p><input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> Crohn's disease</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Intestinal gas</p> <p><input type="checkbox"/> Stomach trouble</p> <p>Psychological</p> <p><input type="checkbox"/> Anxiety/stress</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Irritability</p>	<p>Other</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Cancer/tumors</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Drug/alcohol/tobacco use</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Joint replacement(s)</p> <p><input type="checkbox"/> Thyroid trouble</p> <p>Female Only</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> Menstruation issues</p> <p><input type="checkbox"/> Menopausal hot flashes, etc.</p> <p><input type="checkbox"/> Pregnant currently</p> <p><input type="checkbox"/> How many pregnancies? _____</p> <p>Male Only</p> <p><input type="checkbox"/> Prostrate trouble</p> <p><input type="checkbox"/> Urination issues</p> <p><input type="checkbox"/> Pain in groin</p> <p><input type="checkbox"/> Excessive perspiration</p>
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List other conditions not listed:

Signature: _____ Date: _____