PURE LIFE CLINIC

Name:______________________________ Date of Birth: __________________________

Massage Registration

Patient Information

Today's Date: ________________________

Patient Name: _______________________

Address: _______________________________

____

____

Email___________________________________

Patient SS#______________________________

Sex/Gender: ____________________________

Preferred Pronoun (please circle):

He/Him She/Her They/Their Other: ______

Age_____ **Birthdate**______________________

Marital Status___________________________

Spouse's Name____________________________

CONTACT

Home___________________________________

Cell_____________________________________

Other___________________________________

May we leave a message? Yes No

Occupation______________________________

Employer________________________________

Employer Phone___________________________

IN CASE OF EMERGENCY, CONTACT:

Name_____________________________________

Relationship_______________________________

Phone_____________________________________

How Did you find us?

- ☐ Google
- ☐ Yelp
- ☐ Friend
  - Their name: _______________________
- ☐ Chair massage event
- ☐ Insurance provider

Other:__________________________________

Insurance

Insurance Company________________________

ID #______________________________________

Group #___________________________________

Person responsible for this account? Relationship?

____

Is patient covered by additional insurance?
YES NO

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Massage Intake Form

1. What is the primary reason for seeking massage therapy? ____
____
2. What areas of the body need special focus? ____
____
3. Are there any areas you would **not** like worked on?____
4. Have you ever received a professional massage? Yes No
   If yes, how often do you receive body work? ____
   When was your last session? ____
5. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain ____
6. Do you have any allergies to oils, lotions, ointments? Yes No
   If yes, please explain ____
7. Do you have sensitive skin? Yes No
   If yes, please explain ____
8. Are you wearing [ ] contact lenses [ ] dentures [ ] hearing aid
9. List any exercise activities and frequency. ____
____
10. Do you sit for long hours at a workstation, computer, or driving? Yes No
    If yes, please explain ____
11. Do you perform any repetitive movement in your work, sport, or hobby? Yes No
    If yes, please explain ____
12. Do you experience stress in your work, family, or other aspect of your life? Yes No
    If yes, please explain ____
13. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? ____
____
14. List current medications and purposes:____
____

Provider Signature:____ **Date**_________________________

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15. Please check all of the conditions listed below that applies to you:

[ ] Pregnancy ______ weeks
[ ] Open sores or wounds
[ ] Easy bruising
[ ] Recent accident or injury: ________
[ ] Recent fracture:________________
[ ] Recent surgery:________________
[ ] Artificial joint/limb:_____________
[ ] Sprains/strains:_________________
[ ] Current fever
[ ] Swollen glands
[ ] Allergies/sensitivities
[ ] Heart condition
[ ] High or low blood pressure
[ ] Circulatory disorder
[ ] Varicose veins
[ ] Lupus
[ ] Contagious skin condition
[ ] Deep vein thrombosis/ blood clots
[ ] Joint disorders/ arthritis
[ ] Osteoporosis
[ ] Epilepsy
[ ] Headaches/ migraines
[ ] Cancer
[ ] Diabetes
[ ] Decreased sensation
[ ] Back/ neck problems
[ ] Fibromyalgia
[ ] TMJ/ jaw pain
[ ] Carpal tunnel syndrome
[ ] Tennis elbow
[ ] Phlebitis
[ ] Hernia

16. List any major previous injuries, accidents, illnesses? _______________________________________

____

17. Previous Surgeries? ____

18. Are you currently under the care of a health care professional? Yes No

If yes, please explain ____

19. Is there anything else about your health history or any other information that you think would be useful for your massage therapist to know to plan a safe and effective massage session?

____

____

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health. I understand that a massage therapist cannot diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. Because massage 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 the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature ____ Date __________________

Provider Signature:____________________________________ **Date**_____________________