Alpenglow Acupuncture, LLC

Massage Therapy Intake Form

Name: ______________________________ Date of Birth: ______________

Where do you have pain? ______________________________
Rate your Pain 1(none) to 10 (severe) ________ Sex: **Male** **Female**
Why have you come for a massage? ______________________________
Describe any accidents, injuries or surgeries including dates: ______________________________
____
Allergies to Lotions, Oils, Creams or Fragrances? ______________________________
Allergies to Medications? ______________________________
Are you currently receiving any medical treatment? ______________________________
Please list any medications you are taking: ______________________________

Please check if you are currently experiencing any of the following?
_____Pregnancy __________Flu or Cold, Fever or Infection __________Disease or Inflammation
_____Injury Rash or Skin Condition: If so, where? ______________________________

HABITS:
Exercise:____________________________ Sleep Difficulties? Yes No Please describe:____________

Where do you tend to hold stress in your body? ______________________________
Where do you have any especially tender-to-touch areas? ______________________________

Please answer the following questions and CIRCLE the conditions that apply to you:

Musculoskeletal:
Broken bones / fractures? **Yes** **No** Where? ______________________ When?____________
Muscle Spasm? **Yes** **No** How is your Range of Motion Effected? ______________________
Arthritis? **Yes** **No** Degenerative Rheumatoid Tendonitis Bursitis Carpel Tunnel
Disc Problems? **Yes** **No** Sprains & Strains? **Yes** **No** Where? ________________

Head & Neck: STRESS? **Yes** **No** Injuries?____________ Whiplash? **Yes** **No** When?__________
Headaches? **Yes** **No** Migraines Tension Sinus Stress______________________________

High Blood Pressure Parkinson's Stroke Anxiety Depression Mental Condition Neck Pain
Hand or Arm numbness Tingling Bell's palsy Epilepsy Seizures Other:______________

Diseases: Cancer Anemia Lymphoma Lymphedema Tumors Heart Disease Diabetes
Phlebitis Varicose Veins Circulation problem Hepatitis HIV/AIDS
Blood pathogens______________________________

Respiratory: Asthma Allergies Sensitivity to Scents Cough Smoker Pneumonia
Bronchitis Emphysema Chew Tobacco

Digestion: Acid Reflux Daily BM Constipation Diarrhea IBS Diverticulitis Colitis Crohn's

Skin: Bruise Easy Edema Swollen Glands Rash Eczema Psoriasis
Shingles Herpes Ringworm

Please read & sign the following: I acknowledge that the above information is complete and accurate.

Patient Signature______________________________ **Date:**______________________

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