Cleveland Clinic
Wellness

Center for Integrative Medicine
Massage Intake Form

Name: _____ Date: _____

☐ Male ☐ Female Date of Birth: _____ Referred by/ Relationship: _____

Home Phone: _____ Mobile _____ Email: _____

Occupation(s): _____

Emergency Contact: _____ PhoneNo: _____ Relationship: _____

What are your concerns/symptoms? _____

_____

When did you first notice this concern? _____

What brought it on? _____

What aggravates the condition? _____

What activities relieve the condition? _____

Are the symptoms constant or intermittent? _____

Has a physician given you a diagnosis? Yes ☐ No ☐ What is the diagnosis? _____

Have you ever had an accident? Yes ☐ No ☐ Describe the injuries including dates, location on body, and treatments

(more space on the back of form): _____

_____

Last Surgeries and dates: _____

List any medical conditions that are currently being treated: _____

List any prescription medication (more space on the back of form): _____

List any over the counter medication (more space on the back of form): _____

List any herbs/supplements, homeopathic (more space on the back of form): _____

Do you have tension or soreness in a specific area? _____

Do you have numbness, tingling, or stabbing pain? Yes ☐ No ☐ Please describe: _____

Are you sensitive to touch in a specific area? Yes ☐ No ☐ Please describe: _____

Do you have any allergies (include food and topical allergies): _____

Please circle any of the conditions you are experiencing or are being treated for:

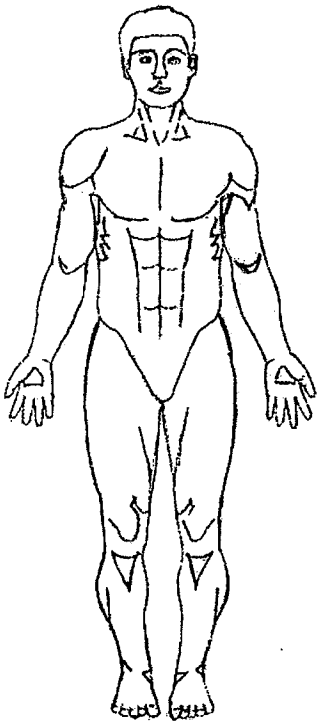
Cardiovascular System
Anemia
Arrythmia
Blood Pressure high/low
Bruising
Congestive heart failure
Dizziness
Fainting
Heart attack
Pacemaker
Varicose Veins
Other
Digestive System
Colitis
Constipation
Diarrhea
Indigestion
Ulcer
Other

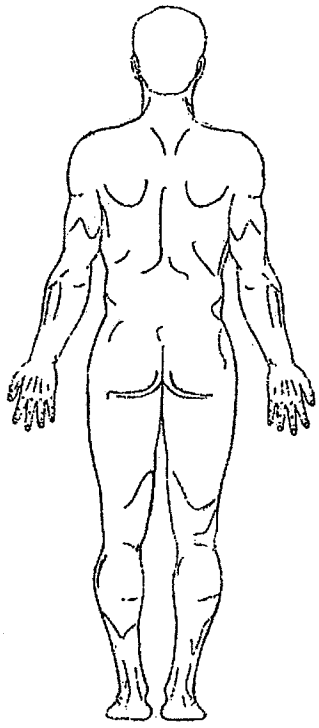
Integumentary System
Itching
Open lesion
Poison ivy/oak
Swelling
Topical Allergies
Warts
Other
Neurological System
Fibromyalgia
Headaches
Migraines
Multiple Sclerosis
Numbness
Seizures
Sleep disturbance
Stroke
Other

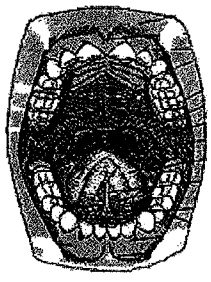
Respiratory System
Asthma
Shortness of breath
Sinus pain
Sinus infection
Other
Cancer
Fever
Other
Musculoskeletal
Arthritis OA/RA
Bursitis
Herniated disc
Joint replacements
Spinal curvatures
TMJ
Other

Reproductive System
Pregnancy
Endometriosis
Fibroids
Endocrine System
Diabetes
Thyroid Hyper/Hypo
Menopause
Hot Flash
PMS
Other
Psycho Social
Alcohol abuse
Anxiety
Body dysmorphia
Depression
Eating disorder
Fatigue

Please use the diagram of the human body to mark the areas that are bothering you and rate each area on a scale of 0-10 (10 being most severe) – Use a P for pain and a T for Tension in the muscles.







Waiver:
This session is for Massage Therapy only. I certify that the Massage Therapist does not have the ability to diagnose medical conditions, perform physical examination, or treat medical conditions. If there are contraindications to massage a referral to my primary care physician will be made. The therapist cannot perform Chiropractic or Osteopathic Manipulations, Electrical Stimulation, Colonic Irrigation, Ultrasound, or Diathermy.

I will inform the Massage Therapist if the rate of pressure needs to be adjusted or if I experience discomfort or pain.

I will inform the Massage Therapist if I want the session to be terminated at any time and the session will end without question.

I certify that I have filled out this form completely and if during the course of my therapy there are changes in my medical history, I will inform the therapist in a timely manner.

Signed:_____

Therapist Signature:_____

Date:_____