

SEATED MESSAGE INTAKE

First Name: _____ M.I.: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone(h): _____ (w): _____ DOB: _____

Is this your first professional massage? _____ Yes _____ No

If yes, is this your first Seated Massage? _____ Yes _____ No

Please list any recent injuries or surgeries: _____

Please list any medications (vitamins, herbs, or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

Are you currently under the care of a physician? _____

Whom? _____

Please list reason(s): _____

Please check all that apply today:

- Infection
- Inflammation
- Fever
- Pregnant/trying to get pregnant

Please check any of the following that you now have or have had:

- | | |
|--|--|
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> Phlebitis/Blood Clotting Conditions |
| <input type="checkbox"/> Neck Injuries | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Back Injuries | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Sore Arms | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Muscle Cramping | <input type="checkbox"/> Nausea/Fainting Spells |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Numbness/Tingling/Nerve Problems |

The above information is accurate and true to the best of my knowledge. I understand that Seated massage work does not constitute medical treatment but rather is a form of health promotion utilizing techniques and principles of various massage modalities. I take responsibility for alerting my therapist to any physical conditions which would affect this work.

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