Colleen Cummings Gaydorus, L.M.T.
NYS License #015142

THERAPEUTIC MASSAGE INTAKE FORM

Your answers to following questions will be kept confidential. They will be seen only by myself and are requested so that I may provide you with better care.

Date:_____
Name:_____
Address:_____
Email Address: _____
Phone: (Day) _____ **(Eve)**_____**(Cell)**_____
Sex_____ **D.O.B.**_____ **Occupation**_____
Emergency Contact Name and Phone numbers:
(Day)_____**(Eve)** _____ **(Cell)**_____
Who is your primary medical practitioner?
_____
Are you currently under that physician's care? _____ **YES** _____ **NO**
Please Describe?
_____
_____
_____
_____
_____

Please list all medications currently taking and for what?
_____
_____
_____
_____
_____

Any allergies?
_____
Do you exercise regularly?_____ **YES** _____ **NO** **What type of exercise do you do ?** _____
Have you received massage /bodywork/chiropractic before? If so, what type_____
_____

REASON FOR MASSAGE/BODYWORK SESSION?

Injury Pain Tension Movement Dysfunction Limited Range Of Motion Relaxation Other_____
_____
Have you seen a physician for this condition ?____**YES** ____**NO.**
Diagnosis?_____

HEALTH HISTORY - Check with P for past and/ or C for current condition

MUSCULOSKELATAL

____ lower back, hip , leg pain
____ neck, shoulder, arm pain
____ headaches/ head injuries
____ spasms/ cramps
____ TMJ/ jaw pain
____ joint bone disease
_____ tendonitis ____ bursitis
____ arthritis _____ gout
____ lupus ____ fibromyalgia
____ osteoporosis
____ other _____

CIRCULATORY

____high ____ low blood pressure
____ blood clots/ hematoma
____ phlebitis / varicose veins
____ heart condition
____ lymphedema
____ other _____

RESPIRATORY

____breathing difficulties
____ asthma
____ emphysema
____sinus issues
____allergies
____thrombus
____ embolism
____ other

NERVOUS

____ numbness/ tingling
____ shingles
____ trigeminal neuralgia
____ bells palsy

SKIN

____ allergies
____ rashes
____ athlete's foot
____ herpes/ cold sores

DIGESTIVE

___diverticulitis
___IBS
___constipation
___ gas/bloating
___ other _____

REPRODUCTIVE

____ pregnant? Stage? _____
____ pms
____ ovarian/menstrual problems
____ other _____

OTHER

_____ anxiety
_____depression
_____ migraines
_____ headaches
_____sleep disorders
_____drug/alcohol addiction/dependency
_____ nicotine/caffeine addiction
_____ chronic fatigue or pain

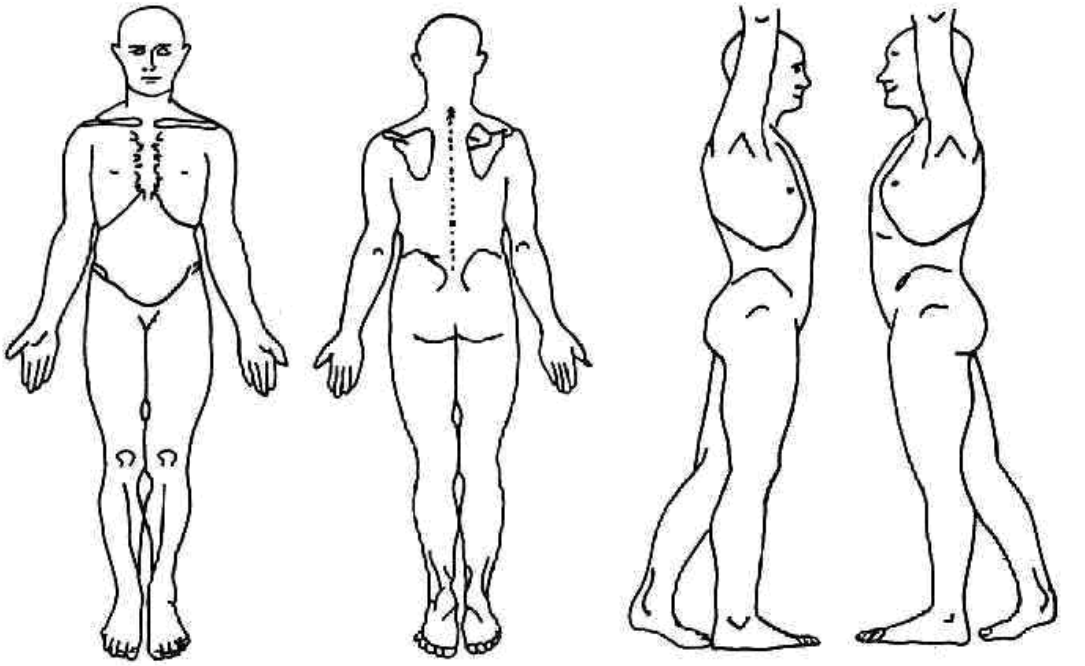
OTHER

____diabetes
____ kidney / bladder ailments
____ cancer / tumors
____ operations

Do any of the following apply today?

Contact lens ?_____
Infection_____
Fever? _____
Inflammation or swelling?_____
_____
Communicable illness?? Please specify_____
_____
_____
_____

Please shade or mark the chart below to indicate any discomfort or areas of desired work today :



front **back** **right** **left**

It is my choice to receive therapeutic massage. I understand that the services provided are not a replacement for medical or psychological care and that the information provided is not prescriptive or diagnostic in nature. I have given to the best of my ability all pertinent information requested of me.

_____

Signature

_____

Date

_____

Signature of Parent/Legal Guardian if under 18y/o

_____

Date

_____