# Solace Spirit Massage Intake Form

## Personal Information

Name: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ Referred by: _____

Date of birth: _____ Marital status: _____

Occupation: _____ Employer: _____

Primary Physician: _____

Emergency Contact: _____ Phone: _____

## Medical Information

What is your major complaint? _____

_____

_____

When did you first notice this? _____

_____

What brought it on? _____

_____

What makes it worse? _____

_____

Is this condition getting progressively worse?
□ yes □ no □ constant □ comes and goes

Is this condition interfering with your:
□ work □ sleep □ daily routine

What have you done to get relief? _____

_____

Are you taking any medications? □ yes □ no
If yes, please list:

_____

_____

Has there been a medical diagnosis? □ yes □ no
If yes, what was the diagnosis? _____

_____

## Massage Information

Are there areas (feet, face, abdomen, etc.) you do not want massaged? □ yes □ no
Please explain: _____

_____

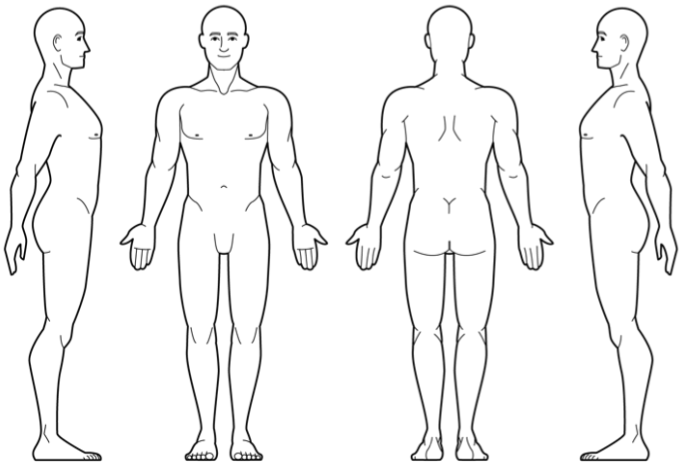
What are your goals for this treatment session?

_____

_____

_____

Please circle any areas of discomfort:



## Miscellaneous Information

Age of mattress: _____
□ Comfortable □ Uncomfortable
Do you use a foam pillow? □ yes □ no
Do you sleep on: □ side □ back □ stomach
Are you wearing:
□ heel lifts □ inner soles □ arch supports □ sole lifts

-turn over-

## Health History

**Musculoskeletal**
___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw pain (TMJ)
___ Lupus
___ Spinal problems
___ Headaches/migraines
___ Osteoporosis
___ Fibromyalgia
___ Spains or strains
___ Plantar fasciitis

**Circulatory**
___ Heart condition
___ Phlebitis/varicose veins
___ Blood clots
___ High/low blood pressure
___ Lymphedema
___ Thrombosis/embolism
___ Stroke
___ Cold hands/feet
___ Dizziness/fainting

**Respiratory**
___ Asthma
___ Breathing difficulty
___ Emphysema
___ Allergies, specify:
_____
___ Sinus problems

**Nervous System**
___ Shingles
___ Numbness/tingling
___ Pinched nerve
___ Chronic pain
___ Paralysis
___ Pins & needles in arms/hands/legs
___ Multiple Sclerosis
___ Parkinson's Disease

**Vision/Hearing**
___ Light bothers eyes
___ Ringing in ears

**Skin**
___ Allergies, specify:

_____
___ Rashes
___ Cosmetic surgery
___ Athlete's foot
___ Herpes/cold sores

**Digestive**
___ Irritable bowel syndrome
___ Constipation
___ Bladder/kidney
___ Colitis
___ Crohn's disease
___ Ulcers
___ Indigestion
___ Intestinal gas
___ Stomach trouble

**Psychological**
___ Anxiety/stress
___ Depression
___ Irritability

**Other**
___ Anemia
___ Cancer/tumors
___ Diabetes
___ Drug/alcohol/tobacco use
___ Fatigue
___ Joint replacement(s)
___ Thyroid trouble

**Female Only**
___ PMS
___ Menstruation issues
___ Menopausal hot flashes, etc.
___ Pregnant currently
____ How many pregnancies?_____

**Male Only**
___ Prostrate trouble
___ Urination issues
___ Pain in groin
___ Excessive perspiration

List other conditions not listed:
_____

_____

Signature: _____ Date: _____