SAINT JOSEPH MERCY HEALTH SYSTEM
A MEMBER OF TRINITY HEALTH

INSPIRIT MASSAGE AND BODYWORK CLIENT INTAKE

PERSONAL DATA

Today's Date: _____ Referred by: _____ Date of Birth:_____/_____/_____

First Name: _____M.I. _____ Last Name: _____

Address: _____ City:_____State: _____ Zip: _____

Phone: (H)_____ (W)_____(Cell)_____

Email:_____ Occupation:_____

Type of physical work tasks: _____

Emergency contact (Name):_____ _____

Phone: _____ Relationship: _____

Are you currently under the care of a health practitioner? Yes No

If yes, name of practitioner:_____

If yes, please list reason or medical diagnosis: _____

_____

HEALTH HISTORY

Is this your first professional massage? _____ If no, how frequently do you get a massage? _____

Have you ever had a problem with massage in the past? Yes No

If yes, please describe _____

Today's primary concern? _____

_____

Do you have physical discomfort? Yes No **If yes, please answer the next 5 questions below:**

How would you describe it (Please Circle):

Intensity: Mild Moderate Severe Duration: Constant Intermittent

With certain movements? Please Describe_____

_____

When did you first notice pain or discomfort? _____

Which activities are difficult or painful to do? _____

_____

Which activities help relieve this pain or discomfort? _____

_____

Which parts of your body do you tend to hold stress? Please Circle all that apply

Head / Neck / Shoulders / Back / Digestive / Arms / Legs / Other _____

Allergies / Sensitivities:

oils _____ lotions _____ scents _____ nuts _____ detergents _____

foods _____ animals _____ latex_____ other_____

Medication Allergies: _____

Have you had any surgeries, hospitalizations, injuries, trauma, or accidents this past year? If yes, please describe: _____

_____

Do you feel that you have recovered from these events? Yes No **Please explain:** _____

_____

Do you have any chronic, ongoing pain that you deal with on a regular basis? Yes No

Please explain: _____

Are you receiving any other type of medical treatment? Yes No

If yes, what type of treatment? _____

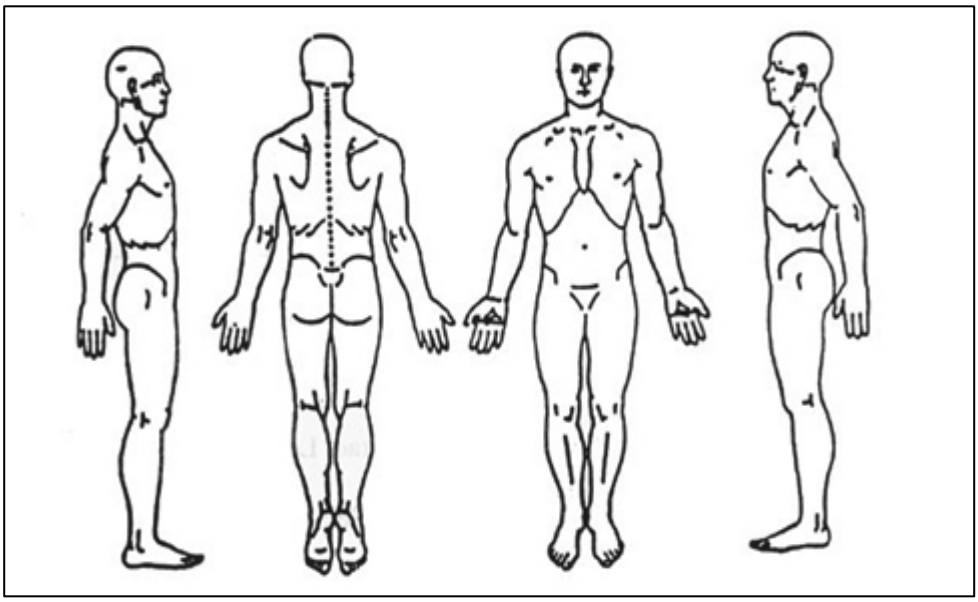
Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

_____

_____

List stress reduction and exercise activities. Include frequency/week._____

Use the symbols below to indicate your symptoms



O = Pain

X = Tightness

→= Radiating Pain (Use arrow in the direction it's going)

___Check if you have no symptoms at this time

Please check any of the following conditions that currently affect you OR that you have experienced in the last 5yrs.

MUSCULOSKELETAL

___ Arm/Hand Pain
___ Bone or Joint Disease
___ Broken/Fractured Bones
___ Bursitis
___ Carpal Tunnel Syndrome
___ Chest/Ribs/Abdominal Pain
___ Cysts
___ Fibromyalgia
___ Gout
___ Headache
___ Hip Pain
___ Joint Stiffness/Swelling
___ Leg/Foot Pain
___ Low Back Pain
___ Mid Back Pain
___ Neck Pain
___ Osteoarthritis / Rheumatoid Arthritis
___ Osteoporosis
___ Plantar Fasciitis
___ Postural Deviations
___ Sciatica
___ Scoliosis
___ Shoulder/Neck Pain
___ Spasms/Cramps
___ Sprains/Strains
___ Tendonitis
___ Thoracic Outlet Syndrome
___ TMJ/Jaw Pain
___ Torticollis
___ Whiplash Syndrome
___ Other
_____
_____

RESPIRATORY

___ Asthma
___ Dizziness
___ Emphysema/COPD
___ Pneumonia
___ Sinus Problems
___ Trouble Breathing
___ Other
_____
_____

Do you smoke? Yes ___No___

CIRCULATORY

___ Anemia
___ Blood Clots/Phlebitis
___ Diabetes
___ Dizziness
___ Heart Condition
___ Hemophilia
___ High Blood Pressure
___ Low Blood Pressure
___ Lymphedema
___ Lymph Node Removal
___ Raynaud's Disease
___ Varicose Veins
___ Other
_____
_____

DIGESTIVE

___ Colitis
___ Constipation
___ Crohn's Disease
___ Diarrhea
___ Gallstones
___ Gas/Bloating
___ Hepatitis
___ Indigestion
___ Irritable Bowel Syndrome
___ Ulcers
___ Other
_____
_____

SKIN

___ Acne
___ Athletes Foot
___ Dermatitis/Eczema
___ Fungal Infection
___ Impetigo
___ Open Wound or Sore
___ Psoriasis
___ Rashes
___ Warts/Moles
___ Other
_____
_____

NERVOUS SYSTEM

___ ALS
___ Bell's Palsy
___ Bulging Disk
___ Cerebral Palsy
___ Chronic Pain
___ Epilepsy
___ Head/Neck Injury
___ Herniated Disk
___ Multiple Sclerosis
___ Neuritis
___ Numbness/Tingling/ Twitching
___ Paralysis
___ Parkinson's Disease
___ Seizure Disorders
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Other

OTHER

___ Anxiety/Panic Attacks
___ Bladder Infection
___ Cancer/Type _____
___ Chronic Fatigue Syndrome
___ Confusion
___ Depression
___ Eating Disorders
___ Edema
___ Grief Process
___ Hearing Impaired
___ Herpes/Shingles
___ HIV/AIDS
___ Insomnia
___ Kidney Disease
___ Loss of Appetite
___ Lupus
___ Menopause
___ PMS
___ Postoperative Situation
___ Pregnancy
___ Sports Injury
___ Substance Abuse
___ Vision Impaired
___ Other

Caffeine Intake- amount/day
_____

Inspirit Massage Therapy Release and Waiver

I acknowledge that the massage therapy provided to me at St. Joseph Mercy Hospital, Inspirit Salon & Spa is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general belief of massage, possible contraindications and the treatment procedure has been explained to me. Contraindications for massage include: cellulitis, fever (unless on antibiotics for 3 days), platelets less than 20,000, neutrophil count less than 1,000, unstable heart conditions, uncontrolled diabetes or hypertension, acute local inflammation, infectious skin rashes, advanced osteoporosis, subdural hematoma, suspected DVTs/phlebitis and varicose veins which are a local contraindication.

I acknowledge that massage therapy is not a substitute for medical treatment or medications and that it is recommended I concurrently work with my primary physician for any medical condition for which I was diagnosed. I take responsibility for alerting my therapist to any physical, mental or emotional changes that occur with my health. I acknowledge that the therapist's knowledge about my health background is very important before I receive a massage and acknowledge that my records will be kept confidential. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are **not** part of massage therapy. I have informed the massage therapist of all known physical conditions, medical conditions, medications and have authorized my caregivers to provide information concerning my physical and medical condition. I acknowledge that the Massage Therapist reserves the right to postpone my appointment if a physician's approval is needed before receiving massage therapy.
I also acknowledge that I may be charged the full price of any cancelled or missed appointments without 24 hours notice (medical emergencies excluded).

Signature of Client **Date**

If the patient is a minor, please have parent/guardian sign below:

Parent/Guardian **(Relationship to Patient)** **Date**

For adult clients who cannot speak for themselves, please have a guardian/DPOA, or family member sign below:

Guardian/DPOA/Family Member **(Relationship to patient)** **Date**

Witness Signature (Clerical or Massage Therapist) **Date**

(revised 4/18/16)