SportsZenergy
Therapeutic & Sports Massage

Client Intake Medical History Form

Personal Information

Name: _____ Phone: (_____) _____

Address: _____ City: _____State: _____Zip: _____

Email: _____ Date of Birth: _____

Occupation: _____Referred by: _____

In case of emergency: _____Phone: (_____)_____

General & Medical Information

If you answer 'yes' to any of the following questions, please explain as clearly as possible.

☐ Yes ☐ No Have you ever had a professional massage?

☐ Yes ☐ No Are you wearing contact lenses?

☐ Yes ☐ No Are you allergic to any oils, lotions, cremes, or nuts? Please specify:

_____

☐ Yes ☐ No Do you have any injuries or conditions that I should be aware of? If yes, please explain in the *comments* section.

☐ Yes ☐ No Do you have any other medical condition that I should be aware of?

_____

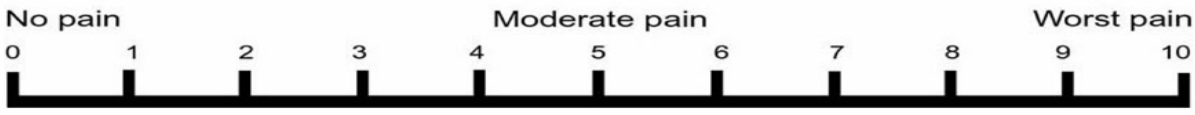
☐ Yes ☐ No Do you sit for long periods of time such at a desk or in a driving position? If yes, please explain in the *comments* section.

Comments: _____

_____

_____

Rate your pain on the scale



Define the quality of your pain: (achy, throbbing, tender, radiating, stabbing, tingling, numbness, spasms)_____

_____

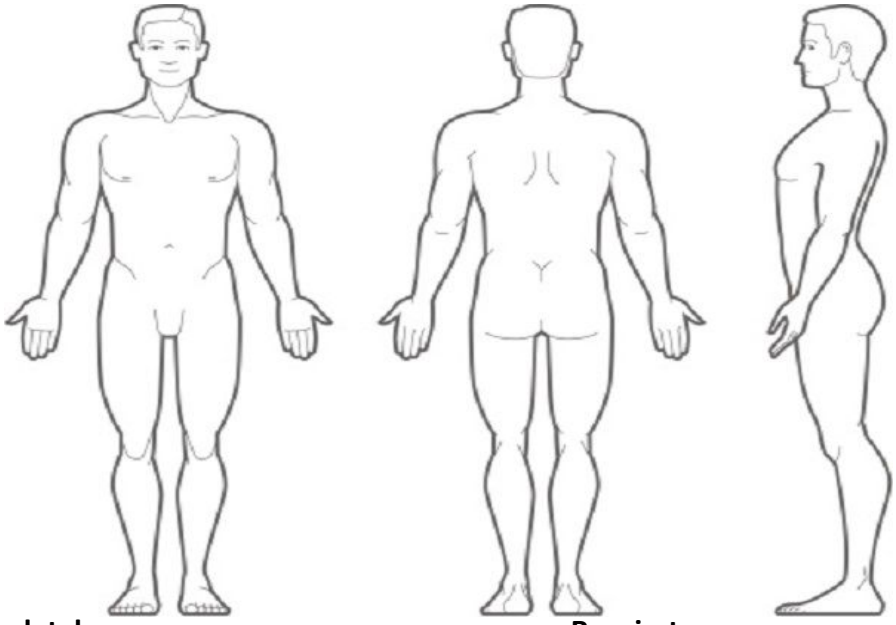
_____

_____

_____

Medical Information

Please circle the specific areas you would like the therapist to concentrate on during your session



Musculoskeletal

___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory

___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Skin

___ Allergies, specify:
_____
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

___ **Psychological**
___ Anxiety/Stress Syndrome
___ Depression

Respiratory

___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify:
_____

Nervous System

___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis

Reproductive

___ Pregnant, stage _____

Other

___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed:
_____
Please explain any of the condition(s) that you have marked above: _____
_____

Prescription Medications

Please list all medications you are currently taking

Medication: ________________________________

Purpose: ___________________________________

Dosage: ______________________________________

Side Effects: _________________________________

Is it effectively treating the conditions: _________

Medication: ___________________________________

Purpose: ______________________________________

Dosage: _______________________________________

Side Effects: __________________________________

Is it effectively treating the conditions: _________

Medication: ________________________________

Purpose: ___________________________________

Dosage: ______________________________________

Side Effects: _________________________________

Is it effectively treating the conditions: _________

Medication: ___________________________________

Purpose: ______________________________________

Dosage: _______________________________________

Side Effects: __________________________________

Is it effectively treating the conditions: _________

Medication: ________________________________

Purpose: ___________________________________

Dosage: ______________________________________

Side Effects: _________________________________

Is it effectively treating the conditions: _________

Medication: ___________________________________

Purpose: ______________________________________

Dosage: _______________________________________

Side Effects: __________________________________

Is it effectively treating the conditions: _________

Medication: ________________________________

Purpose: ___________________________________

Dosage: ______________________________________

Side Effects: _________________________________

Is it effectively treating the conditions: _________

Medication: ___________________________________

Purpose: ______________________________________

Dosage: _______________________________________

Side Effects: __________________________________

Is it effectively treating the conditions: _________

ffice Information

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Office Policies

1. Cancellation and No-Show Policy

We strive to meet our clients' needs for massage by effectively managing our schedule. 24 hour advance notice is required when canceling an appointment, except in cases of illness, emergency or inclement weather.

Cancellations without 24 hour notice will result in a $35 charge for your session, as that time has been set aside specifically for you. The cancellation fee must be paid on the day you notify our office of your need to cancel and must be paid prior to scheduling/receiving your next appointment.

In the event that you fail to show up to your appointment entirely, resulting in a complete loss of time to your therapist, you will be required to pay the full amount for the scheduled session on the day of your missed appointment.

2. Lateness Policy

Our clinic schedules 30 minutes between appointments to accommodate for the time we spend before and after each massage with our clients. Time for your appointment has been arranged especially for you. Please arrive 10-15 minutes early for your appointment as your massage is scheduled to begin at the appointment start time. If you arrive late, your session may be shortened in order to accommodate other whose appointments follow yours and full payment will be expected.

3. Permission to Contact You

Your feedback is important to us as it helps us to understand your specific needs and how we can better serve you. We are committed to delivering the highest level of care for your which is why we would like your feedback after your initial massage appointment. You will receive and email requesting your review of our clinic to complete at your convenience. This feedback provides us the opportunity to learn more about your overall experience so the we can measure the effectiveness of our massage and make modifications, if necessary. Please advise us on how you prefer to be contacted by our clinic.

_____ _____

Preferred email Printed name

_____ _____

Prefer contact # Signature & date