

**Mickie Grist, Licensed Esthetician, LMT
Massage Intake Form**

Date: _____ Name: _____ Referred By: _____

Address: _____

Phone Number: _____ Birthday: _____

Email: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

Would you like us to email you special offers? Yes _____ No _____

Would you like us to call you to remind you of your appointments? Yes _____ No _____

Have you ever had a professional massage? Yes _____ No _____ If yes, date of last massage _____

What are your goals for this session? _____

(relaxation, pain relief, stress relief, injury rehabilitation, maintenance, etc.)

What type of touch do you prefer? Light _____ Medium _____ Deep _____

Are you currently under the guidance of a coach or athletic trainer? Yes _____ No _____

How would you rate your stress of a scale of 1-10? _____

What do you do to reduce stress? _____

Are you currently taking any medications? Yes _____ No _____

Please list medication and why they are prescribed: (include aspirin, herbs, etc.)

Medications: _____

Prescribed For _____

Are you allergic to anything? If yes, what? _____

Health Problems (Check all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rashes | <input type="checkbox"/> Jaw Pain/TMJ |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Allergies | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Contagious Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Hernia/Rupture | <input type="checkbox"/> Migraines | <input type="checkbox"/> PMS | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Asthma | <input type="checkbox"/> Decreased Range of Motion | <input type="checkbox"/> Inflammation |
| <input type="checkbox"/> Whip Lash | <input type="checkbox"/> Depression | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Low Back/Hip Pain |
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neck/Shoulder/Arm Pain | <input type="checkbox"/> Other |
| <input type="checkbox"/> Nervous Condition | <input type="checkbox"/> Serious Accident | <input type="checkbox"/> Skin Disorders | |

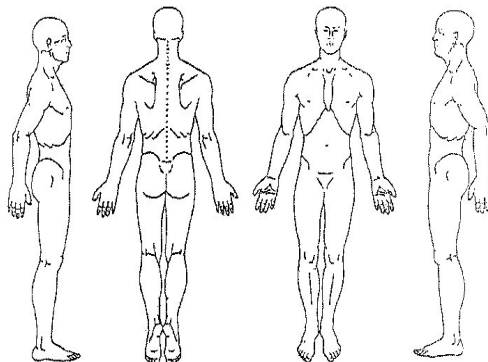
List any surgeries within the past five years _____

List any accidents within the past five years _____

Do you have any of the following today? Sunburn _____ Inflammation _____ Severe Pain _____ Headache _____

Abrasions, Burns, Bruises _____ Irritated Skin Rash _____ Poison Ivy _____ Cold/Flu _____

**Using the diagrams,
please indicate any areas
of pain or discomfort**



DOSHA QUIZ

Answer the following questions and add up your scores.

Body Frame:

- a) I am thin, lanky, or slender with prominent joints and thin muscles.
- b) I have a medium symmetrical muscle build with good muscle development
- c) I have a large, round, or stocky build. My frame is broad, stout, or thick.

Weight:

- a) Low: I may forget to eat or have a tendency to lose weight
- b) Moderate: It is easy for me to gain or lose weight if I put my mind to it.
- c) Heavy: I gain weight easily and have difficulty losing it.

Eyes:

- a) My eyes are small and active
- b) I have a penetrating gaze.
- c) I have large, pleasant eyes.

Complexion:

- b) My skin is dry, rough, or thin
- c) My skin is warm, reddish in color and prone to irritation
- d) My skin is thick, moist, and smooth

Hair:

- a) My hair is dry, brittle, or frizzy.
- b) My hair is fine with a tendency towards early thinning or graying
- c) I have abundant thick and oily hair

Joints:

- a) My joints are thin and prominent and have a tendency to crack
- b) My joints are loose and flexible
- c) My joints are large, well knit, and padded

Sleep Pattern:

- a) I am a light sleeper with a tendency to awaken easily
- b) I am a moderately sound sleeper, usually needing less than eight hours to feel well rested
- c) My sleep is deep and long. I tend to awaken slowly in the morning.

Body Temperature:

- a) My hands and feet are usually cold and I prefer warm temperatures.
- b) I am usually warm regardless of the season, and prefer cooler environments.
- c) I am adaptable to most temperatures, but do not like cold, wet days.

Temperament:

- a) I am lively and enthusiastic by nature. I like to change.
- b) I am purposeful and intense. I like to convince.
- c) I am easy going and accepting. I like to support.

Under Stress:

- a) I become anxious and/or worried
- b) I become irritable and/or aggressive
- c) I become withdrawn and/or reclusive.

Your Personal Score

Total # of a's _____ Total # of b's _____ Total # of c's _____

It is my choice to receive massage therapy and I acknowledge that all therapy received by me is to be of a therapeutic nature for the relaxation and well-being of my body and mind. I agree to communicate with my therapist if I feel that my well being is being compromised. I understand that massage therapists do not diagnose illness, disease or any physical or mental disorders; nor do they do any spinal manipulations or prescribe any medical treatments or pharmaceuticals. I understand that massage is not a substitute for medical examination or diagnosis, and that is recommended that I see my primary physician for those services. I have stated all medical conditions that I am aware of and will advise my therapist of any changes in my health status. I also agree to give at least a 24 hour cancellation notice if I cannot meet my scheduled appointment so that another client may be scheduled in that time slot. Otherwise a \$25 fee will be charged. Thank you for your support.

Signature _____ Date _____