OSPTI
ORTHOPEDIC & SPORTS
PHYSICAL THERAPY INC.

MASSAGE INTAKE FORM

Contact Information Date: _____

Name: _____ DOB: _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____
Name and Relationship

Health History (Check the following conditions that apply, past and present.)

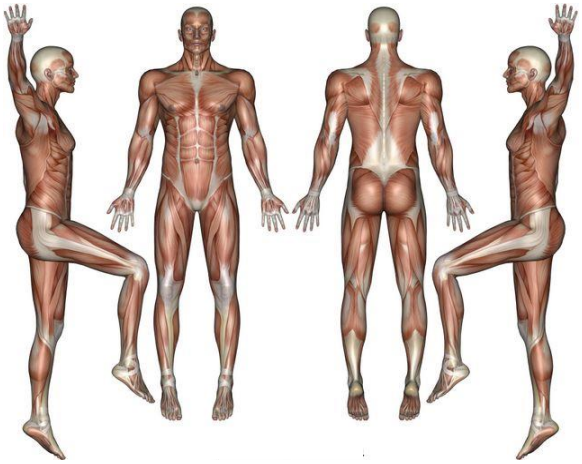
___ Headaches	___ Broken Bones/Fractures/Sprains	___ Foot Disease
___ Allergies	___ Dizziness/Fainting/Shortness of Breath	___ Heart Condition
___ Arthritis/Bursitis	___ High/Low Blood Pressure	___ Fibromyalgia
___ Cancer	___ Surgery	___ Blood Clots

Other: _____

Information for Today (Circle Yes or No)

Are you pregnant?	Yes	No	Do you have any inflammation or pain?	Yes	No
Do you have the flu?	Yes	No	Do you have a fever?	Yes	No

Please indicate by circling on the pictures where your pain is located today.



Where would you like the therapist to focus?
___ Full Body
___ Lower Body
___ Upper Body

Please provide an explanation regarding the checked items.

_____

_____

_____

I have stated all of the conditions that I am aware of and confirm this information to be true and accurate to the best of my knowledge. I will inform the health care provider of any changes in my status.

Signature: _____ Date: _____

Signature of Guardian (for minor consent): _____

Note: Massage is intended to improve circulation and muscle relaxation. To achieve the best results from your massage it is recommended to limit caffeine and drink plenty of water in the next several hours.