Tempo Therapeutic Massage, LLC
Tracy S. Kaufman, MSW, LMT, BCTMB, CPT
Licensed Massage Therapist

CONFIDENTIAL PATIENT INTAKE FORM

Name ______________________________ Date of Birth ____________

Street Address ______________________________

City ____________________ State ________ Zip Code ____________

Phone Numbers (H) ____________ (W) ____________ (C) ____________

Email Address ______________________________

Please add my name to the mailing list to receive information regarding massage specials and promotions _____ *Yes* _____ *No Thanks*

(Email is never shared outside Tempo Therapeutic Massage, LLC)

Occupation ______________________________

Emergency Contact (Name) ____________________ (Phone) ____________

Referred By ____________________

My name may be used to thank referral source ____ Yes ____ No

Is this your first massage? _____ Yes _____ No

What results would you like from your massage session? (Mark all that apply)

_____ Relaxation/Stress reduction
_____ Decrease pain/Pain management
_____ Decrease muscle stiffness
_____ Increase mobility
_____ General wellness
_____ Other (Please define) ____________

What type of physical activities do you do for work and recreation?

____

____

Specify and prioritize problem areas on which you would like your massage to focus

____

____

Are there any body areas you prefer NOT to be massaged? (Mark all that apply)

_____ Face _____ Head _____ Neck _____ Hands _____ Chest
_____ Abdomen _____ Arms _____ Forearms _____ Hips _____ Feet
_____ Other (Please define) ______________________________

IMPORTANT:
Please indicate if you have any of the following conditions. Dependent upon the stage of the condition and your current state of health, standard massage techniques may not be appropriate.

____ Pregnant
____ Cancer
____ Radiation Therapy
____ Lymph Node(s) Removed
____ Stroke
____ High Blood Pressure
____ Blood Clot(s)
____ Recent Injury/Bruising
____ Fever/Acute Infection
____ Osteoporosis
____ Diabetes
____ Swelling/Edema/Inflammation
____ HIV/AIDS/Hepatitis/Infectious Disease
____ Chronic Pain Treatment
____ Undiagnosed Acute Pain
____ Kidney Disease
____ Disease of the Nervous System
____ Gastrointestinal or Liver Disease
____ Disease of the Heart or Blood Vessels

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How would you rate your state of health?
______ Excellent ______ Good ______ Fair ______ Poor

Are you currently under the care of a physician? ______ Yes ______ No
If yes, for what reason(s)? ____

____

Have you taken any narcotic pain medication or muscle relaxants within the last 12 hours?
______ Yes ______ No

Are you currently taking any medications, including over the counter drugs, herbal or nutritional supplements, and/or topical hormones?
______ Yes ______ No
If yes, what medications and for what reason(s)? ________________________________

____

List any Surgeries ____

____

Accidents:
- Less than 5 years ago (explain) ________________________________
- Greater than 5 years ago (explain) ________________________________

List any Allergies ____

Are there any other current or previous health conditions that may be affecting your health or functioning?
______ Yes ______ No
If yes, please explain ____

____

Are you currently experiencing pain? ______ Yes ______ No
If yes, please describe ____

____

The above information is accurate and true to the best of my knowledge. I understand that the massage therapist does not diagnose illness or disease, does not prescribe medications, and does not perform spinal manipulations. I understand that massage therapy is not a substitute for medical examination, diagnosis, and treatment, and that it is recommended that I see my primary health care provider for any condition I might have. I will inform my massage therapist of any changes in my health, or of any conditions that may be a contraindication to massage at each appointment. The benefits of massage and possible contraindications for massage have been explained to me. I have received a copy of the Tempo Therapeutic Massage, LLC *Services and Policies* brochure and I understand them and agree to abide by them. I consent to receive massage therapy from Tracy S. Kaufman, Licensed Massage Therapist and Managing Member of Tempo Therapeutic Massage, LLC.

Signature ________________________________ Date ________________

Printed Name ________________________________