LINDSEY GODSMARK, L.M.T.
LICENSED MASSAGE THERAPIST
MASSAGE THERAPY INTAKE FORM

Medical History and Information

*Please check any or all that apply to your **present** health:*

___ Headaches
___ Acute Pain; Where? ____________________
___ Chronic Pain; Where? ____________________
___ Muscle/Joint Pain; Where? ________________
___ Sprains/Strains; Where? _________________
___ Herniated Disc; Where? _________________
___ Numbness/Tingling; Where? _______________
___ Arthritis; Where? _______________________
___ Skin Conditions; What Kind? ______________
___ Mental Disorder; What Kind? ______________
___ High/Low Blood Pressure

___ Fatigue
___ Sleep Difficulties
___ Varicose Veins
___ Sinus Problems
___ Vision Problems/Contacts
___ Osteoarthritis
___ Osteoporosis
___ Scoliosis
___ Jaw Pain/Teeth Grinding
___ Diabetes/Hypoglycemia
___ Kidney Condition

Women Only

___ Pregnant; How far along? ________________
___ Painful Menstruation
___ Endometriosis
___ Menopause

Men Only

___ Prostate Problems

*Please check all that apply to your **past** health:*

(If Present condition, please place a "P" on the line provided)

___ Cancer/Tumors; Where? __________________
___ Blood Clots; Where? ____________________
___ Infectious Disease; What Kind? ____________
___ Acid Reflux/GERD
___ Stroke/TIA
___ Heart Attack
___ Ulcers

Any other health conditions or concerns that you would like me to know? ________________

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Lindsey Godsmark, L.M.T.
Licensed Massage Therapist
Massage Therapy Intake Form

Name: ______________________________ Male: ____ Female: ____

Address: ______________________________ Phone #: ______________________

______________________________ Alt. Phone #: ____________________

Date of Birth: ____/_____/_____ Age: ____________

Occupation: __________________________

Emergency Contact: ______________________________

Relationship: ____________________________________

Phone #: ____

Medications/Herbs/Supplements: ____

____

____

Allergies: ____

Do you smoke? Yes__ No __ If so, How Much? ____

Drink Alcohol? Yes __ No __ If so, How Often? ____

Body Piercings? Yes __ No __ Is so, Where? ____

Surgeries/Major Injuries (In the past few years): ____

____

____

Exercise (Type/How often?): ____

____

Have you ever had Massage Therapy before? Yes __ No __

If so, What type? ____________________________________

Do you know what kind of pressure you like? Light __ Medium __ Deep __ Not Sure __