



Cherry Creek Myotherapy
 Relaxation and Rehabilitative Massage Therapy
 mchelle1229@gmail.com 406-290-8991

Massage Therapy Intake Form

Name: _____ Date of Birth: _____
 Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
 E-mail address: _____
 Address: _____ City: _____ St: _____ Zip: _____
 Referred by: _____ Have you ever had a professional massage before? _____
 If so, how often? _____ Do you exercise? _____ Frequency: _____
 Please describe what type of exercise _____
 Other daily activities: _____ Occupation: _____
 Primary Care Physician: _____ Chiropractor: _____
 How do you relieve stress or pain? _____

What are the reasons for your visit today?

What are your other health concerns?

Describe any surgeries you have had:

Describe any accidents you have had:

List all conditions currently monitored by a Health Care Provider:

List any medications that you took today:

Please note all current and previous conditions:

Headache	Y	N	Stiff/painful joints	Y	N
Sleep Problems	Y	N	Neck, shoulder, or arm pain or numbness	Y	N
Fatigue	Y	N	Low back, hip or leg pain or numbness	Y	N
Flu or cold symptoms in the last 48 hours	Y	N	Sciatica	Y	N
Sinus	Y	N	Depression	Y	N
Allergies to scents or lotions	Y	N	Blood clots	Y	N
Allergies, in general	Y	N	Stroke	Y	N
Arthritis	Y	N	Heart disease	Y	N
Osteoporosis	Y	N	High/low blood pressure	Y	N
Scoliosis	Y	N	Poor circulation	Y	N
Broken bones	Y	N	Asthma	Y	N
Disc problems	Y	N	Thyroid dysfunction	Y	N
Spasms/cramps	Y	N	Diabetes	Y	N
TMJ (jaw pain)	Y	N	Currently pregnant	Y	N
Tendonitis/bursitis	Y	N	Malignant cancer or tumors	Y	N
Spinal Problems	Y	N	Benign cancer or tumors	Y	N
Varicose Veins	Y	N			

Describe, as needed, any conditions indicated above, or other conditions that you feel may be important