MASSAGE THERAPY PATIENT INTAKE FORM

Brandy Sorensen, LMT Nancy Abernethy, LMT Sarah Rikansrud-Dranberg, LMT Paula Taylor, LMT

9212 Evergreen Way
Everett WA 98204

Name: _____ DOB: _____ M/F Date _____

Cell Phone _____ Email _____

Address _____ Apt# _____

City _____ State _____ Zip _____ SS# _____

Parent/Guardian (if minor) _____ Cell phone _____ OK to receive text? Y / N

Employer _____ Occupation _____

How did you hear about our office? _____

Is today's visit due to: Auto Accident? _____ Work-related injury? _____ Other? _____

Date of Injury: _____ Are you pregnant? _____ Week # _____

Have you received massage prior to today? _____ For injury or relaxation? _____ Date last massage: _____

Massage style preference: ☐ light pressure ☐ medium pressure ☐ deep pressure ☐ trigger point therapy

Other: _____

Current medications (incl pain relievers): _____

_____

Daily activities limited by condition: _____

_____

Work duties limited by condition: _____

_____

Sleep affected by condition? If yes, please explain: _____

List surgeries, major injury/illness in past three years (e.g. arthritis, diabetes, high blood pressure, car accident): ____

_____

_____

_____

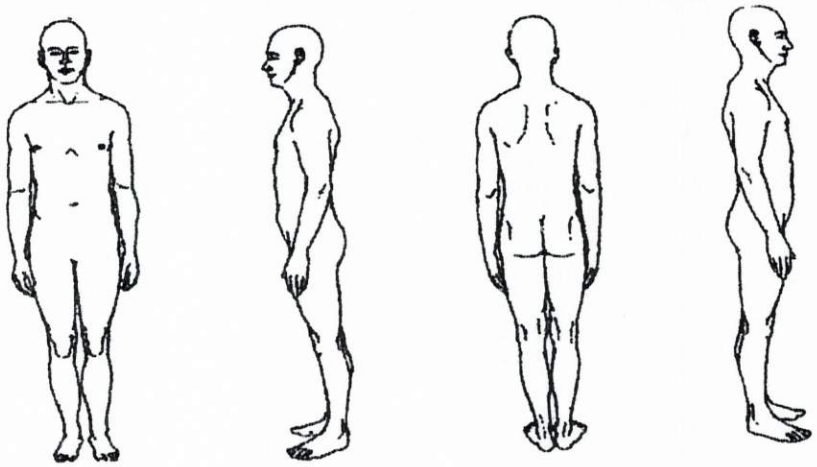
Are you currently experiencing any of the following? If yes, please list body area:
Pain/tenderness _____ Numbness/ tingling _____
Stiffness _____ Swelling _____ Allergies or skin conditions _____
Decreased range of motion (neck/arms/shoulders/hips/legs) _____

_____

_____

List any pain relievers and/or medications taken **today**: _____

On the figures below, please circle or put an X marking areas of concern/pain:



Print Name _____ Signature _____ Date _____