Feeling Great
Therapeutic Massage & Lymphatic Therapy

Intake Form

370 Maple Ave. W Suite 2
Vienna, VA 22180
(703)663-8600

Personal Information

Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email: _____
Occupation: _____
Emergency Contact: _____ Phone: (_____) _____

Referred by/How did you hear about us?
_____
May we send you special offers via email?
☐ Yes ☐ No

What is the reason of your visit? ___ **Wellness/Relaxation** ___ **Pain & Condition Management**

The following information will be used to plan a safe and effective massage session.
Please answer the questions to the best of your knowledge.

Part 1: General Questions

Have you ever had a professional massage before? ☐Yes ☐No

Are you sensitive to touch or pressure in any area? ☐Yes ☐No

Do you see a Chiropractor or Physical Therapist? If yes, please circle one ☐Yes ☐No

Is this a Prenatal massage? ☐Yes ☐No
How many months of pregnancy? _____

Is this a Postnatal massage? ☐Yes ☐No
How many weeks after delivery? _____
Vaginal birth or C-section? Please circle one

Part 2: Medical History

Please mark ALL current and previous conditions that apply.

General
- ☐ Current headache/migraine
- ☐ Decreased Sensation
- ☐ Sensitivity / easy bruising

Cardiovascular
- ☐ Heart condition / pacemaker
- ☐ Chest pain or pressure
- ☐ Swelling of legs
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Thrombosis/Atherosclerosis
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ High/Low blood pressure
- ☐ Aneurysm
- ☐ Cardiac arrhythmia

Gastro-Intestinal
- ☐ Crohn's disease
- ☐ Abdominal pain
- ☐ Surgical Implant (mesh or other)
- ☐ GI inflammation
- ☐ Diverticulitis/Diverticulosis

Urinary
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Urinary tract infection
- ☐ Dialysis

Musculoskeletal
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Hernia
- ☐ Rheumatoid arthritis
- ☐ Tennis / golfer's elbow
- ☐ TMJ / carpal tunnel syndrome
- ☐ Frozen shoulder
- ☐ Current Sprain / strain
- ☐ Artificial joint / limb
- ☐ Fibromyalgia
- ☐ Scoliosis
- ☐ Plantar Fasciitis

Hematologic/Lymphatic
- ☐ Enlarged lymph nodes (glands)
- ☐ Lymph nodes removed
- ☐ Diagnosed with lymphedema
- ☐ Frequent bruising

Neurological
- ☐ Strokes
- ☐ Seizures
- ☐ Epilepsy

Skin
- ☐ Cellulitis
- ☐ Rash
- ☐ Major scars
- ☐ Lumps
- ☐ Contagious disease/skin condition

Allergies
- ☐ Sinus congestion
- ☐ Allergic to: _____

Emotional
- ☐ Stress
- ☐ Anxiety
- ☐ Difficulty sleeping
- ☐ Depression

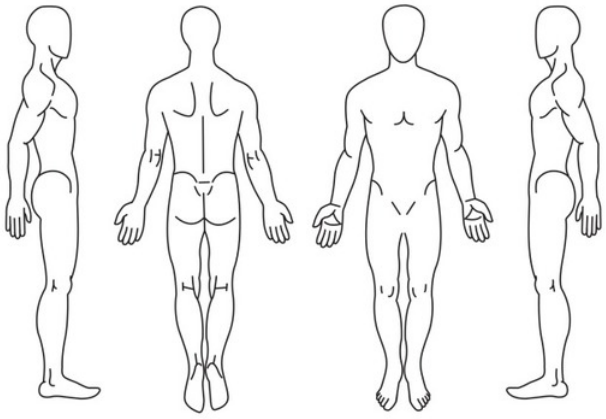
For cancer patients:
- ☐ Currently undergoing cancer treatments?
  ___ Yes ___ No
- ☐ Have permission from your treatment team to receive Massage at this time?
  ___ Yes ___ No
- ☐ Date of your last treatment:
  Chemo? _____
  Radiation? _____
- ☐ Lymph nodes removed?
  ___ Yes, how many? _____
  ___ No

Other:
- ☐ _____
  _____
  _____
  _____
  _____

If applicable, please list recent accident or injury and ALL surgeries/procedures:

Circle One	Date	Area/Procedure
Accident/ Injury / Surgery		
Accident/ Injury / Surgery		
Accident/ Injury / Surgery		
Accident/ Injury / Surgery		
Accident/ Injury / Surgery		

Please use the diagram to circle problem area:



If you are here for pain & condition management, please explain the problem:

_____
_____
_____
_____

Are you currently taking medications? If so, please list reason for prescription:

_____
_____
_____

Part 3: Signature

I understand that the massage I receive is provided for the basic purpose of relieving muscular tension and/or relaxation. **If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.**

Client Signature: _____ Date _____

Practitioner Signature: _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize Feeling Great, LLC to administer Massage therapy or Bodywork techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____