Standley Lake Massage Therapy, Inc.

8725 Wadsworth Blvd. Arvada, CO 80003
303-425-7298

SESSION INTAKE QUESTIONNAIRE

CHART NO. _____

Please Print

NAME	DATE
ADDRESS & CITY, STATE, ZIP	BIRTH DATE SEX (M / F)
	OCCUPATION
HOME PHONE # AND CELL PHONE # (INCLUDE AREA CODE)	HOW DID YOU HEAR ABOUT US?
WORK PHONE # (INCLUDE AREA CODE)	MAY WE THANK SOMEONE FOR SENDING YOU IN? PLEASE PRINT NAME (REFERRALS RECEIVE A $10 DISCOUNT)
E-MAIL ADDRESS (NEVER SOLD, FOR SLMT, INC. USE ONLY)	
EMERGENCY CONTACT/RELATIONSHIP	EMERGENCY CONTACT PHONE #
PRIMARY MEDICAL PRACTITIONER / PHONE NUMBER	

MAIN COMPLAINT (REASON FOR SEEKING MASSAGE THERAPY)

WHAT KINDS OF MEDICATIONS/NUTRITIONAL SUPPLEMENTS ARE YOU TAKING?

Please identify and describe any areas of discomfort by shading in problem areas on the diagram.

CIRCLE ONE

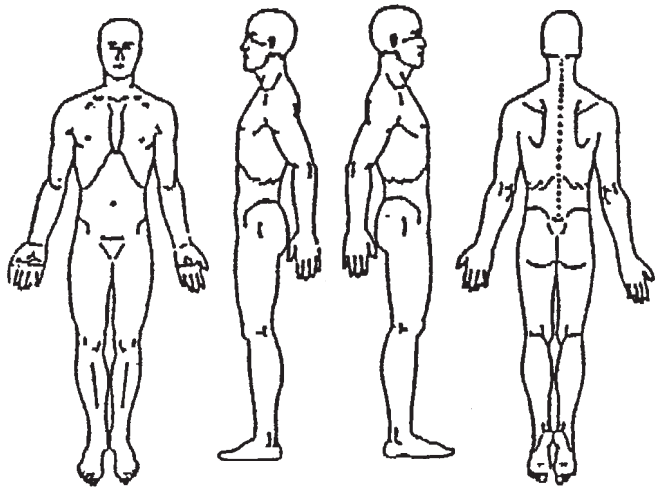
Onset: sudden, gradual Date of onset _____
Duration: hours, days, weeks, months
Frequency: seldom, intermittent, frequent, constant
Type: sharp, dull, achy, tingly
Severity: mild, moderate, severe

_____

_____

_____

_____



FOR OFFICE USE ONLY: ❑ CUSTOMER SATISFACTION CHECKUP INITIALS_____ DATE_____

DO YOU HAVE PROBLEMS WITH: (PLEASE CHECK THOSE THAT APPLY)

L	R		L	R			
							WHIPLASH
		HANDS			PAIN DOWN LEG/SCIATICA		CIRCULATION/BRUISING
		ELBOWS			NUMBNESS/TINGLING IN EXTREMITIES		RHEUMATOID ARTHRITIS
		ARMS			LOW BACK PAIN		OSTEOARTHRITIS
		SHOULDER PAIN			NECK PAIN		ASTHMA/ALLERGIES
		FOOT PAIN			JAW PAIN/TMJ		ABDOMINAL PAIN
		ANKLES			HEADACHES		CONSTIPATION
		KNEES			SPRAINS/FRACTURES/DISLOCATIONS		MENSTRUAL PAIN

IS THERE ANY AREA THAT IS TENDER TO THE TOUCH OR ESPECIALLY SENSITIVE?

IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS, PLEASE CIRCLE IT:

ANGINA	FATIGUE/LOW ENERGY
COLD EXTREMITIES	PREGNANCY (IN THE LAST YEAR)
HARDENING OF THE ARTERIES	SURGERY (IN THE LAST YEAR)
HEPATITIS A B OR C (CIRCLE ONE)	ACCIDENTS OR FALLS (IN THE LAST YEAR)
HIGH OR LOW BLOOD PRESSURE	HOSPITALIZATIONS (IN THE LAST YEAR)
STROKE	RECURRENT INFECTION
THROMBOPHLEBITIS	HIV POSITIVE
USE OF ANTICOAGULANTS (SALICYLATE, HEPARIN, COUMADIN, ETC.)	EPILEPSY
VARICOSE VEINS	SKIN CONDITIONS OR OPEN WOUNDS
CANCER	HERPES
DIABETES	OSTEOPOROSIS
RECENT COLD/FLU (LAST FOUR WEEKS)	MEDICAL IMPLANTS

IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT YOU BEFORE YOUR TREATMENT?

Thank you for completing this form. Please feel free to ask any questions. Now, or in the course of our work together, remember that I, as your massage therapist, am not a doctor and any suggestions made during your visit are recommendations, not prescriptions.

Being under the effects of alcohol or certain medications during massage can put you at risk for injury.
We reserve the right to refuse service.

Client/Patient Signature _____ **Date** _____
(Parent/Guardian if under 18 years of age)