RIPPLE
WELLNESS FOR ALL

MASSAGE INTAKE

Welcome! Thank you for choosing Ripple for your health care needs.
We are here to help and are excited to share our passion for healing.

Thank you for taking the time to fill out these forms. This information gives us a comprehensive picture of your health status and improves our ability to address your health concerns.

Name:	Date:	Date of Birth:

What are you looking to get out of your massage visit?

Have you had professional massage before?_____ If so, what were the results?

What seems to help the condition the most?

What seems to aggravate the condition the most?

Do you have any chronic or recurring health issues?

List any physical activities you do regularly (sports, strenuous tasks, etc)

Please indicate if any of the following apply to you:

- ☐ Back/neck pain issues
- ☐ Bruise easily
- ☐ High blood pressure
- ☐ Blood Clots
- ☐ Cancer
- ☐ Headache
- ☐ Stroke
- ☐ Insomnia
- ☐ Arthritis
- ☐ Chronic pain
- ☐ Heart condition
- ☐ Muscle pain / strain
- ☐ Auto-immune condition
- ☐ Broken bones or dislocation
- ☐ Psychological condition
- ☐ Stroke
- ☐ Scoliosis
- ☐ TMJ / Jaw pain
- ☐ Recent surgery
- ☐ Whiplash
- ☐ Numbness / tingling
- ☐ Contagious skin disorder (warts, athletes foot, etc)

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☐ Addictive issues (alcohol, drugs, food, etc)

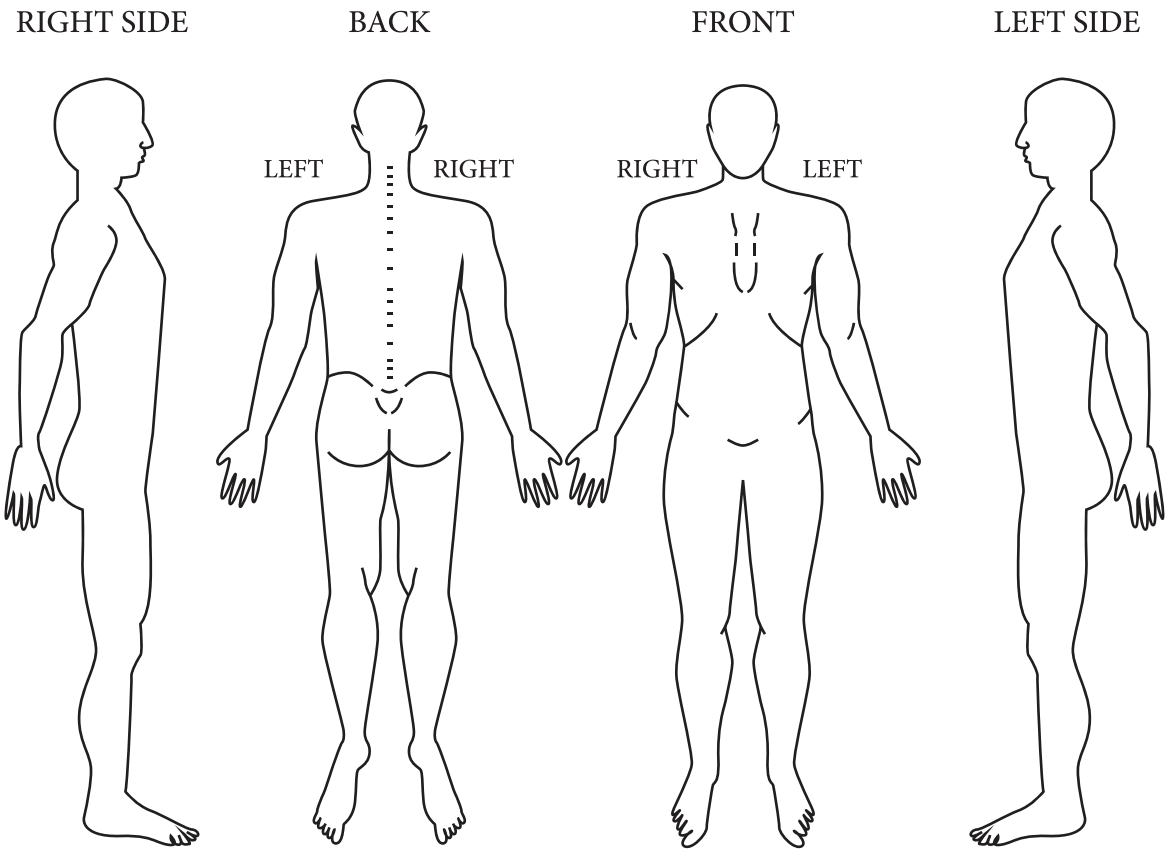
☐ (Women) Pregnant

☐ (Women) Painful Menstruation

☐ Other (HIV/AIDS, Fibromyalgia, Chronic fatigue, Lupus, etc).

Please describe _____

If there is physical pain or disability associated with this condition, please mark where it affects below:



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INFORMED CONSENT

I understand that the massage given to me by the massage therapist is for the purpose of (stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated here.)

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any conditions I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any change.

Responsible Party Signature _____

Date _____