Medicine Wheel Dental & Wellness Center

520.743.7101

Mercedez Lucke, LMT

Cranial Sacral/Massage and Percussion Table Intake Form

Client Information

Name _____ Date _____

Street _____ Day Phone ( ) _____

City _____ State _____ Zip _____ Eve Phone ( ) _____

Occupation _____ Date of Birth _____

Emergency Contact Name and Phone _____ ( ) _____

Referred By _____ Email _____

Massage History / Session Information

Have you ever received a professional massage? ☐ Yes ☐ No Date of last massage _____

What result do you want from your massage sessions? _____

List any exercise activities. Include frequency: _____

_____

Are you currently under the care of a health care practitioner? ☐ Yes ☐ No

If yes, specify purpose: _____

List current medications and purpose: _____

_____

Previous History (Include year and treatment received)

Injuries/accidents/illnesses still affecting you: _____

_____

Surgeries: _____

_____

Please mark any of the following that you now have or have had.

Musculoskeletal

- ☐ Bone or joint disease
- ☐ Tendonitis / Bursitis
- ☐ Arthritis / Gout
- ☐ Jaw pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Other : _____

Circulatory

- ☐ Heart Condition
- ☐ Phlebitis / Varicose Veins
- ☐ Blood Clots
- ☐ High / Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis / Embolism
- ☐ Other : _____

Please mark any of the following that you now have or have had. (Continued)

Respiratory

- ☐ Breathing difficulty / Asthma
- ☐ Emphysema
- ☐ Allergies specify: _____
- ☐ Sinus Problems
- ☐ Other : _____

Nervous System

- ☐ Shingles
- ☐ Numbness / tingling
- ☐ Pinched Nerve
- ☐ Other : _____

Reproductive

- ☐ Pregnant: Stage
- ☐ Ovarian / menstrual problems
- ☐ Prostate
- ☐ Other : _____

Additional Client Remarks / Comments:

_____

_____

_____

_____

Skin

- ☐ Allergies specify: _____
- ☐ Rashes
- ☐ Athletes foot
- ☐ Herpes / cold sores
- ☐ Other : _____

Digestive

- ☐ Irritable bowel syndrome
- ☐ Ulcers
- ☐ Other : _____

Other

- ☐ Cancer / tumors
- ☐ Bladder / kidney ailment
- ☐ Diabetes
- ☐ Drug / alcohol / caffeine / tobacco use
- ☐ Chronic fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Migraines / headaches
- ☐ Anxiety / stress syndrome
- ☐ Depression
- ☐ Contact lenses (hard or soft)

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.

I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.

I understand that massage therapy is a therapeutic health aide and is non-sexual.

I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.

I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

Signed _____ Date _____