Flashpoint Acupuncture

127 S. 5th Street
Suite 120
Quakertown, PA 18951

Phone 484-695-5200
Fax: 877-702-4225
www.flaspointacupuncture.com

Massage Therapy Intake

Initials_____Acct#_____

Last Name First Name Middle Initial
Preferred name Age Date of Birth #
Gender: ☐ Male ☐ Female Marital Status M S D W
Home Address /City /State /Zip Code
Home Phone # Cell Phone# Work Phone#
Email:
Occupation □Full time □Part time □Student □Retired
Employer/School
Address /City /State /Zip Code
Emergency Contact Name Relationship Phone
What is the best way to communicate with you between office visits? (E-mail, Home, Work, Cell phone)
Is there any place you ***do not want me*** to leave a message?
Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.
How did you hear about us_____Referred by _____

Draping will be used during the session for massages - only the area being worked on will be uncovered. During a Reiki sessions you will be fully clothed. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session and an Informed written consent form must provided by parent or legal guardian.

I,_____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

By signing below I verify that the above information is correct and true to the best of my knowledge
Signature **Today's Date**

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Name_____**Date**_____**Acct#**_____

Yes	No	Please check any condition listed below that applies to you	Yes	No	Please check any condition listed below that applies to you
		Have you had a professional massage before			Are you wearing contact lenses
		Do you have any allergies to oils, lotions, or ointments?			Are you wearing dentures or Hearing aids
		Do you have sensitive skin			Do you have a Heart pacer
		Do you have any metal in your body			Do you have difficulty lying on your front, back, or side

Please check any condition listed below that applies to you

	contagious skin condition		recent surgery		swollen glands		joint disorder
	open sores or wounds		artificial joint		heart condition		decreased sensation
	easy bruising		circulatory disorder		High/low blood pressure		cancer
	recent accident or injury		sprains/strains		varicose veins		Other
	recent fracture		current fever		osteoporosis		

Please explain any condition that you marked above_____

Is there anything else about your health history that you think would be useful for me to know??_____

What are the most important health concerns? Please list in order of importance.

1.	Date of onset	Intensify of Pain 1 to10 (the most pain)
2.	Date of onset	Intensify of Pain 1 to10 (the most pain)
3.	Date of onset	Intensify of Pain 1 to10 (the most pain)

Are you currently or in the past received other medical treatment (s) or alternative therapies for this problem (PT/Chiropractic, etc)	
What other treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?	
Get temporary relief? does it fixes problem ? Does it causes side effects?	

What movements are **difficult** for you?

	Sitting		Walking		Getting out of a chair/seated position (getting out of car)
	Standing		Walking **down** the stairs		Bending down
	Lifting		Walking **up** the stairs		Sleeping
	Driving		Squatting		**Other**

	Is the pain		**It better with**		**Is there**		**Is there**
	Dull & Achy		better with Heat		Tendonitis		a heavy feeling
	Sharp/Stabbing		better with Activity		Arthritis		a lump
	Burning/Tingling		better with Rest		Bursitis		a twitching
	Does it move		better with Pressure		Muscle Cramps		stiffness
	is it Fixed		better with Cold		Joint Swelling		tenderness

Please mark problem areas on diagram any area of pain or injury **Make your comments here**