



STAY FIT
Physical Therapy & Core Wellness, Inc.™

GET FIT • STAY FIT

Stay Fit Massage Intake Form

Name: _____ D.O.B. ____/____/____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Email: _____

How did you hear about us? _____

Is this your first massage? _____ If no, how many massages have you had? _____

Waiver and Release

I understand that the massage I receive is provided for the purpose of relaxation and the relief of muscular tension only. I have no known medical condition that would contraindicate massage and understand that massage therapists are not qualified to diagnose, adjust, prescribe, or treat any physical or mental illness. This consent is intended as a waiver of liability for all massage therapists employed by Stay Fit Physical Therapy & Core Wellness, Inc., as well as Stay Fit Physical Therapy & Core Wellness, Inc.

Signed by: _____ Date: _____

(Please Print)

Signature: _____ Witness: _____

Stay Fit Health Questionnaire

Personal Information

Name: _____ Right Handed: Left Handed:

Education: Elementary High School Trade School College Graduate School

Employment: Full Time Part Time

Describe your daily activity or job position: _____

Activities: Sports _____

Hobbies _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

Physical History

Please list most current injuries/accidents: _____

Have you ever received physical therapy? _____ If yes, when & why? _____

Please list any recent surgeries? _____

Lifestyle

Do you smoke? Y/N

Do you drink alcohol? Y/N

How many hours of sleep do you average per night? _____

Describe your current exercise program? _____

Personal Evaluation

Check all that apply.

Unable to participate in normal hobbies/interests? <input type="checkbox"/>	Nervousness? <input type="checkbox"/>
Significant Stress: Work <input type="checkbox"/> Home <input type="checkbox"/> Other <input type="checkbox"/>	Forgetfulness? <input type="checkbox"/>
Difficult with self care? <input type="checkbox"/>	Grief due to family death? <input type="checkbox"/>
Excessive moodiness? <input type="checkbox"/>	Transportation problems? <input type="checkbox"/>
Depression? <input type="checkbox"/>	Other? <input type="checkbox"/>

