Client Health Intake Form

Personal Data

Name: _____ Date:_____ Referred By:_____

Address: _____ 1º Phone:(cell, home, work)-_____

City: _____ State:____ Zip:_____ 2º Phone:(cell, home, work)-_____

E-mail:_____ Date of Birth: _____

Occupation/Employer: _____

Primary Care Provider: _____ Phone:_____

May we consult with primary care provider? Please initial if yes: ☐ Yes _____ ☐ No

Emergency contact: _____ Phone:_____

Massage History/Treatment Information

Have you ever received a professional massage? ☐ Yes ☐ No If yes, date of last massage_____

What results do you want from your sessions? _____

_____

Prioritize areas of your body that you prefer to be massaged? _____

_____

Please check any areas of your body where you prefer ***not*** to receive massage:

☐head ☐face ☐neck ☐arms ☐chest ☐abdomen ☐back ☐buttocks ☐legs ☐feet ☐ other_____

Are you currently seeing a health care practitioner? ☐ Yes ☐ No If yes, please explain _____

_____

_____

Are you currently seeing a Counselor, Psychotherapist, or a Support Group? ☐ Yes ☐ No If yes, please explain_____

_____

List Stress Reduction and Exercise Activities. Please include frequency: _____

_____

_____

List current Medications, Herbals & Supplements and reason for use. Please include OTCs such as aspirin, ibuprofen, Claritin, etc. _____

_____

Previous History (Include year & treatment received)

Surgeries: _____

Accidents: _____

Health History

Musculoskeletal

- ☐ Bone or Joint Disease
- ☐ Tendonitis/Bursitis
- ☐ Broken/Fractured Bones
- ☐ Arthritis/Gout
- ☐ Jaw pain/TMD
- ☐ Lupus
- ☐ Sprains/Strains
- ☐ Low Back, Hip, Leg Pain
- ☐ Neck, Shoulder, Arm Pain
- ☐ Headaches, Head Injuries
- ☐ Spasms/Cramps
- ☐ **Other:**_____

Circulatory

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

Respiratory

- ☐ Breathing Difficulty/Asthma
- ☐ Emphysema
- ☐ Allergies; Specify:_____
- ☐ Sinus Problems
- ☐ **Other:**_____

Nervous

- ☐ Herpes/Shingles
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ **Other:**_____

Reproductive

- ☐ Pregnant; Trimester: _____
- ☐ Ovarian/Menstrual Problems
- ☐ Prostate
- ☐ PMS
- ☐ **Other:**_____

Skin

- ☐ Allergies; Specify:_____
- ☐ Rashes
- ☐ Athletes Foot
- ☐ Herpes/Cold Sores
- ☐ Warts
- ☐ **Other:**_____

Digestive

- ☐ Constipation
- ☐ Gas/Bloating
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Ulcers
- ☐ **Other:**_____

Other

- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Eating Disorders
- ☐ Sleep Disorders
- ☐ Bladder/Kidney ailment
- ☐ Drug/Alcohol Addiction
- ☐ Caffeine/Tobacco Addiction
- ☐ Migraines/Headaches
- ☐ Anxiety/Stress Syndrome
- ☐ Depression
- ☐ Contact Lenses

Consent & Contract for Care:

It is my choice to receive massage therapy and I give my consent to receive treatment. 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 cannot diagnose illness, disease, or any other medical, mental, or emotional disorder. Nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I realize that the treatment is being given for the well being of my body, mind and spirit. This includes stress reduction, relief from muscular tension, spasm or pain, also for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my wellbeing is compromised. I acknowledge that massage is not a substitute for medical examination or diagnosis; 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.

PATIENT SIGNATURE:_____ **DATE:**_____

THERAPIST SIGNATURE:_____ **DATE:**_____