Massage Therapy Client Health Intake Form

Name:_____

_____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

E-mail: _____

Occupation: _____ Date of Birth: _____

Emergency Contact Person: _____ Phone: _____

Are you currently under a physicians care for an acute or chronic illness? Y ___ N ___

If yes please explain: _____

If yes, who is your health care provider: _____

Are you currently taking any prescribed medication or dietary supplements? Y ___ N ___

If yes please explain: _____

_____

Have you received a massage before? Y__ N__ If yes, when: _____

How did you hear about me? _____

What are your goals for this session? _____

Please list areas of tension, stress and/or pain you wish to be addressed: _____

_____

_____

Please mark an (X) by all current conditions:

__ Abdominal /digestive problems
__ Allergies
__ Anxiety
__ Arthritis/tendonitis
__ Asthma or lung condition
__ Athletes foot
__ Blood clots
__ Chronic pain
__ Circulatory/heart problems
__ Constipation/diarrhea
__ Depression
__ Diabetes
__ Fatigue
__ Headaches, migraine
__ Hearing problems
__ Hernia
__ High blood pressure
__ Jaw pain/TMJ pain
__ Low blood pressure
__ Muscle/bone injuries
__ Muscle/joint pain
__ Numbness/tingling
__ Pregnancy
__ Rash/fungus
__ Sinus problems
__ Sleep difficulties
__ Spinal disorders
__ Sprain/strain
__ Tension/stress
__ Vision problems
__Varicose veins
__ Other _____

Elaborate on noted areas above: _____

_____

_____

Please list any recent injuries or surgeries within the past 5 years: _____

_____

_____

Please list your stress-reduction activities, hobbies, exercise and/or sport participation: _____

_____

_____

I understand that Massage Therapy involves the manipulation of the body through manual techniques. I am aware that certain adverse side effects may result. These include, but are not limited to: bruising, and the possible aggravation of symptoms. I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage/bodywork I receive is for the purpose of stress reduction and the relief from muscular tension, spasm or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications/treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services.

Client Signature: _____ Date: _____