Massage Therapy Client Health Intake Form

Patient Information

Name: _____

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

Cell Phone: _____ Home Phone: _____ Date of Birth: _____

E-mail: _____ Occupation:_____

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? _____

Areas you wish to be addressed today:_____

Health Information

Please mark an (X) by all current conditions and (P) for all past conditions

___ Abdominal or digestive problems
___ Allergies
___ Anxiety
___ Arthritis/tendonitis
___ Asthma or lung cond.
___ Athletes foot
___ Blood clots
___ Chronic pain
___ Circulatory/heart problems
___ Constipation/diarrhea
___ Depression
___ Diabetes
___ Fatigue
___ Headaches, migraines
___ 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: _____

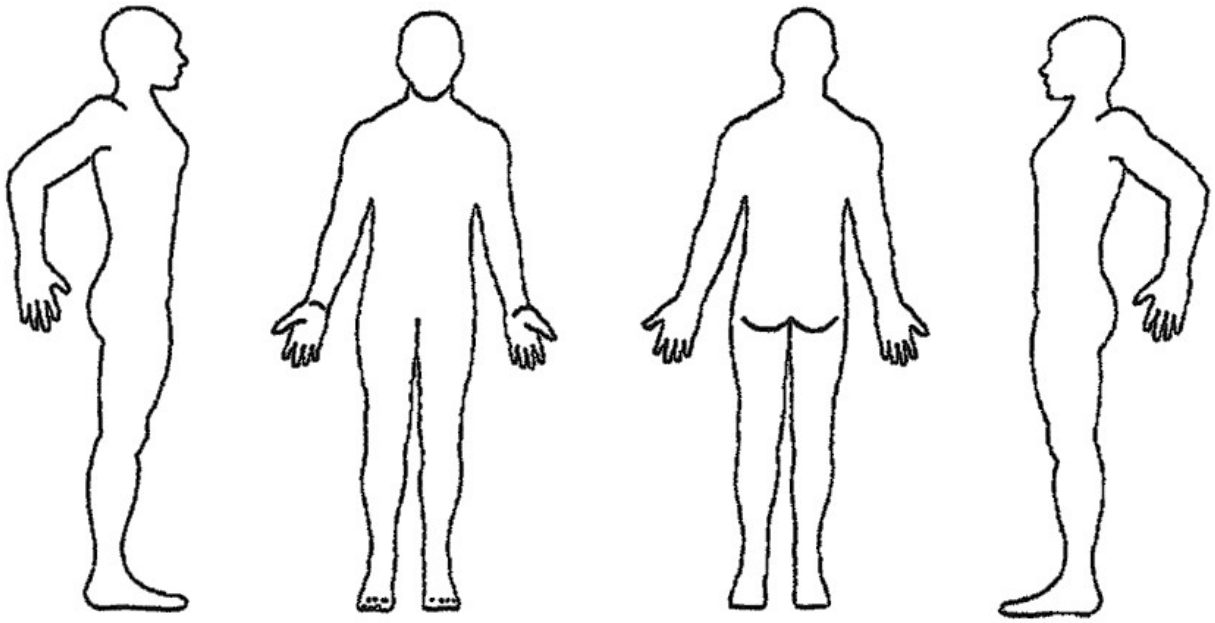
_____

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

_____

Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling



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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. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated. I understand that I am receiving massage therapy at my own risk.

Client Signature: _____ Date: _____