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:				
Are you currently under a physician	s care for an acute	or chronic illness?	YN	
If yes please explain:				
If yes, who is your health can				
Are you currently taking any prescri	ibed medication or	dietary supplemer	nts? Y N	
If yes please explain:				
Have you received a massage before	e? Y N If y	yes, when:		
How did you hear about me?				
What are your goals for this session	?			
Areas you wish to be addressed toda	ay:			
1				

Health Information

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

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

Elaborate on noted areas above:

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

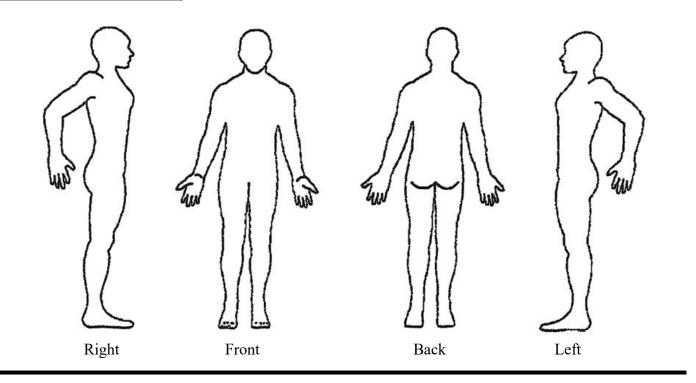
Please list your stress-reduction activities, hobbies, exercise and/or sport participation:

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



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:

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