Confidential Health Intake Form for Massage Therapy

Please fill out all information as accurately and thoroughly as possible. It is better that you give me what you consider too much information, rather than not give me enough information.

THIS BOX FOR OFFICE USE:

Date: _____ Client ID: _____

Name: _____ Email: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Emergency Contact (their relationship to you): _____ Emergency Contact phone: ____-____-____

Home Phone: ____-____-____ Work Phone: ____-____-____ Cell: ____-____-____

Occupation: _____ Employer: _____ Rate your pain from 0-10(10 most severe: _____

Have you ever received a massage before? (If yes, how was it?) _____ Were you referred by anyone? _____

What (specifically) would you like to receive from this massage? _____

Would you like me to focus on any specific area(s)? _____ Stay away from any specific area(s)? _____

Hobbies (optional): _____ Do you exercise regularly (explain)? _____

Health Information/Medical History:

Please consider past and current condition(s) (Please circle Y=Yes or N=No):

Accident/Fall? Y/N	Contagious/Infectious Disease? Y/N	Stroke or Heart Attack? Y/N
Broken Bones? Y/N	HIV? Y/N	High Blood Pressure? Y/N
Sprains/Strains? Y/N	Jaw Pain/Teeth Grinding/TMJ? Y/N	Low Blood Pressure? Y/N
Acute Injury? Y/N	Surgery in the Last 3 years? Y/N	Other Heart Conditions? Y/N
Chronic Pain? Y/N	Smoker? Y/N	Blood Clots? Y/N
Muscle or Joint Pain? Y/N	Alcohol? Y/N	Diabetic? Y/N Dementia? Y/N
Tendonitis? Y/N	Recreational Drugs? Y/N	Depression? Y/N
Arthritis? Y/N	Allergies? Y/N	Nervous Tension? Y/N
Numbness and Tingling? Y/N	Sinus Problems? Y/N	Anxiety? Y/N
Decreased Range of Motion? Y/N	Skin Problems? Y/N	Sleep Difficulties? Y/N
Disk Problem? Y/N	Scoliosis? Y/N	Fatigue? Y/N
Neck Pain? Y/N	Varicose Veins? Y/N	Fibromyalgia? Y/N
Upper Back Pain? Y/N	Epilepsy? Y/N	
Mid Back Pain? Y/N	Seizures? Y/N	Women Only: Pregnant? Y/N
Low Back Pain? Y/N	Headaches/Migraines? Y/N	Painful Menstruation? Y/N
Osteoporosis? Y/N	Vision Problems? Y/N	
Autoimmune Disorder? Y/N	Nausea? Y/N	Men Only: Prostate Problems? Y/N
Cancer/Tumors? Y/N		

Are you currently suffering from any pain related to a traumatic experience? (i.e.: Car accidents, sports injuries, surgeries) Y/N

If yes, briefly explain (what and when): _____

Are you currently taking any medications or supplements (prescription and non-prescription) Y/N

If yes, name(s) of medication(s), reason for taking and dosage: _____

Do you have any conditions that I should be made aware of? Y/N if yes, please list: _____

Do you have any conditions that may require a doctor's note? Y/N if yes, please list: _____

Is it okay for me to contact your other healthcare provider(s)? Y/N if yes, Info: Name: _____ Phone#: ____-____-____

I attest that the above is true and accurate to the best of my knowledge

Signature _____ Date: _____

Parental Guardian Signature (for clients under 18) _____ Date: _____

Disclaimer: ***By signing above, I agree that*** I understand a massage therapist is not a doctor and cannot prescribe medications or diagnose medical conditions. I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. If necessary, I have been cleared by my physician to receive massage therapy and will get a doctor's note if required. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I am responsible for all charges for all services provided. I agree to provide 24 hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee.