Client Health History Intake

Name_____ Date of Birth _____ ☐ Male ☐ Female

Address_____ City/State/Zip_____

Phone: (H)_____ (C)_____ Occupation_____

E-mail address_____ Receive E-newsletter? ☐ Yes ☐ No

Physician/Chiropractor_____ Referred By: _____

Emergency Contact _____ Phone: _____

Current Medications/OTC/Supplements & WHY: _____

_____

Please answer the following to the best of your knowledge.

Have you received professional massage before? ☐ Yes ☐ No How recent? _____

Do you have allergic reactions ☐ Yes ☐ No If yes, please explain_____

What massage pressure to you prefer? ☐ Light ☐ Medium ☐ Firm

What is your goal for this massage session? _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you are currently under medical supervision, please explain_____

Please check any condition/symptom listed below that applies to you:

Musculoskeletal
- ☐ Arthritis
- ☐ Broken Bone
- ☐ Bursitis/Tendonitis
- ☐ Fibromyalgia
- ☐ Jaw Pain (TMJ)
- ☐ Osteoporosis
- ☐ Spinal Problems
- ☐ Whiplash
- ☐ Other _____

Nervous
- ☐ Chronic Pain
- ☐ Multiple Sclerosis
- ☐ Numbness/Tingling
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Seizures
- ☐ Shingles
- ☐ Spinal Cord Injury
- ☐ Other _____

Circulatory
- ☐ Atherosclerosis
- ☐ Blood Clots
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Heart Condition
- ☐ High/Low Blood Pressure
- ☐ Leukemia
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Other _____

Skin
- ☐ Burns
- ☐ Cold Sore/Herpes
- ☐ Infection
- ☐ Open Sores/Wounds
- ☐ Rashes
- ☐ Psoriasis
- ☐ Warts
- ☐ Other _____

Lymph/Immune
- ☐ Allergic Reactions
- ☐ Chronic Fatigue
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Other_____

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Sinus Problems
- ☐ Other _____

Digestive System
- ☐ Colitis
- ☐ Crohns
- ☐ IBS
- ☐ Ulcers
- ☐ Other _____

Miscellaneous Conditions
- ☐ Cancer
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ Migraines/Headaches
- ☐ Pregnant
- ☐ Other_____

Have you recently had an injury, surgery, or areas of inflammation: ☐ Yes ☐ No If yes, please describe _____

_____

Do you exercise regularly? ☐ Yes ☐ No If yes, please describe _____

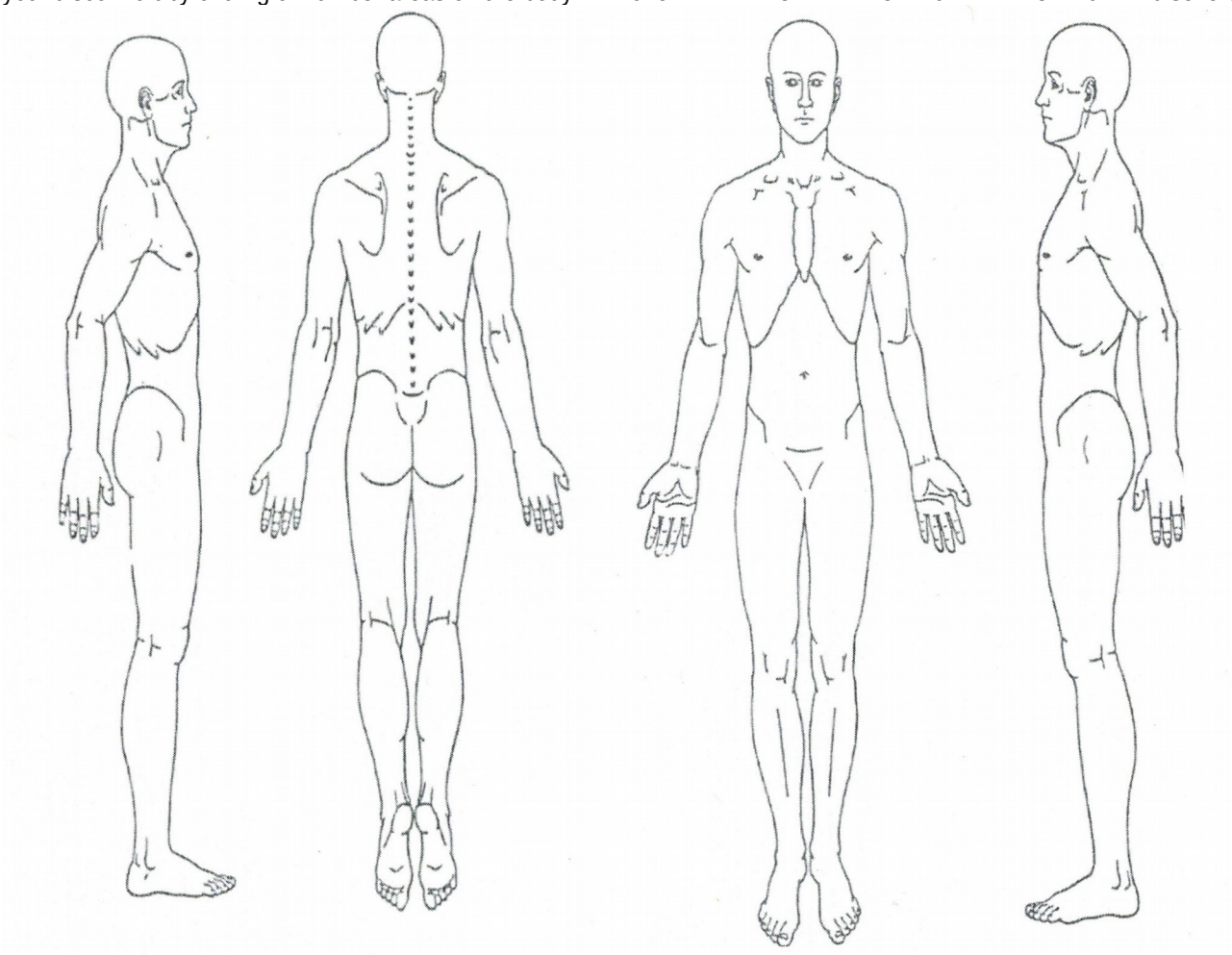
_____

Are you experiencing pain or stabbing pains? ☐ Yes ☐ No If yes, please describe _____

Please mark on the body forms with an **"X"** where you are experiencing any tension, stiffness or other discomfort. Please describe the sensation (burning, stinging, aching, pins-n-needles, etc.):_____

_____

Please rate your discomfort by circling or number areas on the body: none 1 2 3 4 5 6 7 8 9 10 severe



Do these symptoms interfere with your activities of dialing living (e.g. sleep, exercise, work, childcare)? ☐ Yes ☐ No If yes, please describe

_____

Consent to Massage Therapy Treatment

I am aware of the benefits and risks of massage and give my consent for massage. I acknowledge massage therapy is not a substitute for medical care and that massage therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I also understand that it is my responsibility to inform the practitioner of any existing medical conditions I may have, and keep the massage therapist informed of any changes in my health and medications in the future, and understand that there shall be no liability on the practitioner's part should I fail to do so. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand I have the right to refuse massage therapy treatment at any time during the session. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature_____ Date_____

Consent to treatment of Minor I hereby authorize massage therapy techniques to my child or dependent as deemed necessary.

Signature_____ Date_____