Health Intake Form

Name: Date:
Address:
Phone: Gender: Birthdate: Occupation:
Would you like to receive occasional emails regarding massage specials? Yes No
Email:
Emergency contact: Phone:
Referred by:

Massage Information
Have you ever received a professional massage before? Yes No How recently?

List your current symptoms/issues:

What physical activities and/or hobbies do you frequently engage in?

Explain any injuries/accidents or surgeries you've had that I should know about:

What kind of pressure do you prefer? Light Medium Firm
Are you comfortable lying face down for an extended period of time? Yes No
Are you pregnant? Yes No If so, how many weeks?

List any allergies that might be in lotions I use: (nuts, oils, plant based products, etc.):

Health History; Please circle conditions that you have/had. Explain any treatment received and when. (C=Current, P=Past)

Muscular System:
C P Joint pain/stiffness
C P Spinal condition/Scoliosis/Degenerative discs
C P Arthritis (rheumatoid, osteoarthritis)
C P Broken/dislocated bones
C P TMJ dysfunction/jaw pain
C P Osteoporosis
C P Frequent muscle spasms/cramps
C P Sprains/strains
C P Tendonitis/Bursitis

Nervous System:
C P Headaches, Migraines How often:
C P Head injuries, concussions
C P Numbness or tingling Where/how often:

C P Spinal injury
C P Sciatic pain, shooting pain
C P Epilepsy, seizures
C P MS, Parkinson's, Chronic pain, Fibromyalgia
C P Dizziness, Ringing in the ears
C P Memory Loss, Confusion, Easily overwhelmed
C P Depression, anxiety

Respiratory/Cardiac/Vascular:
C P Respiratory infection/condition/Sinus infection
C P Blood clots/Clotting disorder/Bruise easily
C P Congestive Heart Failure/Heart Attack/Stroke/Heart Conditions
C P Swelling /Edema/Lymphadema
C P Varicose veins
C P High/Low blood pressure
C P Shortness of breath/Asthma

Other:
C P Cancer/Tumors
C P Digestive conditions (e.g. Crohn's, IBS)/Bloating/Constipation
C P Kidney disease, infection
C P Diabetes/Endocrine/thyroid conditions
C P Skin condition (rash, burn, athletes foot, warts)
C P Contagious disease List:
C P Other:

List any medications you take and what they are for: (Note: some massage techniques may be contraindicated for certain medications)

Consent for Treatment: (Initial each section)

_____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 that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

_____Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

_____I 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.

_____Your health information will remain confidential and not disclosed to anyone without your authorization.

_____Cancellation policy: $25 for same day cancellations; Full charge of session for no shows

Client Signature: Date:

Parent/Guardian Signature (for minors): Date: