

Massage Therapy Client Health Intake Form

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**Patient Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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: \_\_\_\_\_

Please list areas of tension, stress and/or pain you wish to be addressed: \_\_\_\_\_

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**Health Information**

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

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

Elaborate on noted areas above: \_\_\_\_\_

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

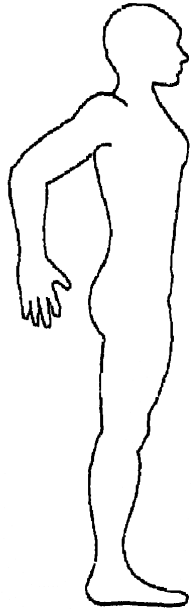
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Please list your stress-reduction activities, hobbies, exercise and/or sport participation: \_\_\_\_\_

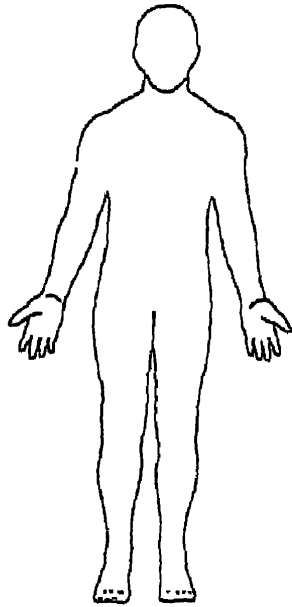
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Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

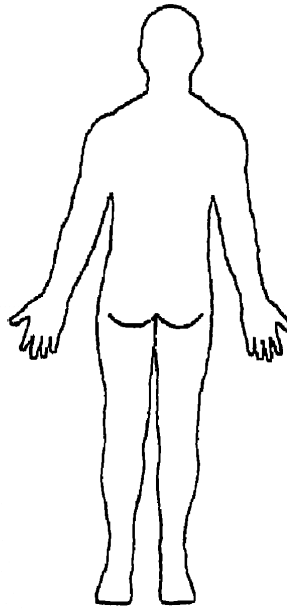
P= pain or tenderness  
S= joint or muscle stiffness  
N= numbness or tingling



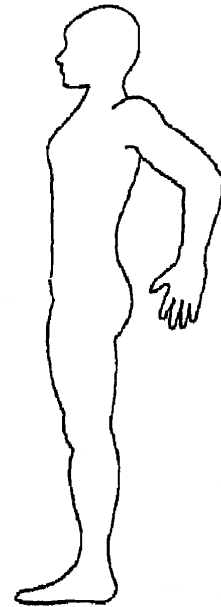
**Right**



**Front**



**Back**



**Left**

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. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_