

CONFIDENTIAL CLIENT INTAKE FORM

Name: _____ Email: _____ Date: ____/____/____
Address: _____ Phone – Day: (____) _____ - _____
City/State/Zip: _____ Phone – Eve: (____) _____ - _____
Birthday: ____/____/____ Occupation/Employer: _____
Do we have permission to consult with your primary provider? Please initial if yes: Yes _____ No
Emergency Contact: _____ Phone: (____) _____ - _____

Have you ever received a professional massage? Yes No

If yes, frequency: _____ Date of last massage: _____

Please tell us who referred you/how you heard about us: _____

Advertisement: _____ Signage: _____ Phone Book: _____ Other: _____

What results do you want from your massage? _____

Are you currently seeing a medical practitioner? Please explain if yes. Yes No _____

List current medications, including aspirin, ibuprofen, herbs, supplements, etc. _____

List stress reduction and exercise activities. Include frequency. _____

MEDICAL HISTORY (Include year and treatment received)

Surgeries: _____

Accidents/Injuries: _____

Having a complete medical history is important for our assessment process and in the determination of your customized massage plan. In each of the following sections please mark the “past” and/or “current” box next to any of the items that apply to your health history.

MUSCULOSKELETAL

Past	Current		Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	bone or joint disease	<input type="checkbox"/>	<input type="checkbox"/>	low back, hip, leg pain
<input type="checkbox"/>	<input type="checkbox"/>	tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	neck, shoulder, arm pain
<input type="checkbox"/>	<input type="checkbox"/>	bursitis	<input type="checkbox"/>	<input type="checkbox"/>	headaches/head injuries
<input type="checkbox"/>	<input type="checkbox"/>	broken/fractured bones	<input type="checkbox"/>	<input type="checkbox"/>	spasms/cramps
<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	jaw pain
<input type="checkbox"/>	<input type="checkbox"/>	sprains/strains	<input type="checkbox"/>	<input type="checkbox"/>	lupus
<input type="checkbox"/>	<input type="checkbox"/>	other (please explain): _____			

CIRCULATORY

- | Past | Current | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | heart conditions |
| <input type="checkbox"/> | <input type="checkbox"/> | varicose veins |
| <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> | lymphedema |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

SKIN

- | Past | Current | |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | athlete's foot |
| <input type="checkbox"/> | <input type="checkbox"/> | warts |
| <input type="checkbox"/> | <input type="checkbox"/> | other: _____ |

NERVOUS SYSTEM

- | Past | Current | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | numbness/tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | chronic pain |
| <input type="checkbox"/> | <input type="checkbox"/> | herpes/shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | sleep disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | other: _____ |

DIGESTIVE

- | Past | Current | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | gas/bloating |
| <input type="checkbox"/> | <input type="checkbox"/> | diverticulitis |
| <input type="checkbox"/> | <input type="checkbox"/> | irritable bowel syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | other: _____ |

RESPIRATORY

- | Past | Current | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | breathing difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | other _____ |

REPRODUCTIVE

- | Past | Current | |
|--------------------------|--------------------------|-------------------|
| <i>PMS</i> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | bloating |
| <input type="checkbox"/> | <input type="checkbox"/> | cramps/pain |
| <input type="checkbox"/> | <input type="checkbox"/> | mood swings |
| <input type="checkbox"/> | <input type="checkbox"/> | breast tenderness |
| <input type="checkbox"/> | <input type="checkbox"/> | other: _____ |

MENSTRUAL CYCLE

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | painful periods |
| <input type="checkbox"/> | <input type="checkbox"/> | irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | absent periods |
| <input type="checkbox"/> | <input type="checkbox"/> | pregnancy - if current # wks? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | perimenopause /menopausal symptoms |
| <input type="checkbox"/> | <input type="checkbox"/> | other: _____ |

OTHER

- | Past | Current | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | cancer/tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | thyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | eating disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | depression |
| <input type="checkbox"/> | <input type="checkbox"/> | drug/alcohol addiction |
| <input type="checkbox"/> | <input type="checkbox"/> | nicotine/caffeine addiction |
| <input type="checkbox"/> | <input type="checkbox"/> | hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> | other: _____ |

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my therapist any time I feel my well being is being compromised. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. I have stated all medical conditions that I am aware of and will update the massage therapist of any changes in my health status.

SIGNATURE _____

DATE _____

THIS BOX FOR OFFICE USE ONLY

Type of care:

- | | | |
|-----------------------------|--|-----------|
| <input type="checkbox"/> TC | <input type="checkbox"/> Req. MD clearance | Comments: |
| <input type="checkbox"/> CM | <input type="checkbox"/> Consult w/ MD | |
| <input type="checkbox"/> PC | <input type="checkbox"/> Refer | |