Massage Therapy Client Health Intake Form

Patient Information

Name: _____

Address: _____ City: _____ State: ____

Zip: _____

Home Phone: _____ Work/Cell Phone: _____

E-mail:_____

Occupation: _____ Date of Birth M/D: _____

Emergency Contact Person: _____ Phone: _____

Are you currently under a physician's 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 I may need

to know about? 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:

_____

Health Information

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

__ Abdominal /digestive __ Depression __ Pregnancy complications

__Diabetes __ Rash/fungus __ Allergies __ Fatigue __ Sinus problems __ Anxiety

__ Headaches, migraine __ Sleep difficulties __ Arthritis/tendonitis __ Hearing problems

__ Spinal disorders __ Asthma or lung cond. __ Hernia __ Sprain/strain __ Athletes foot

__ High blood pressure __ Tension/stress __ Blood clots __ Jaw pain/TMJ pain

__ Vision problems __ Chronic pain __ Low blood pressure __Varicose veins

__ Circulatory/heart __ Muscle/bone injuries __ Muscle/joint pain __ Numbness/tingling

__ Other _____

Elaborate on noted areas above:

_____

Please list any recent injuries or surgeries within the past 5 years that may be affected by

our session: _____

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:_____