MASSAGE CLIENT INTAKE FORM

Name: _____ Date_____
Address: _____
City/State/Zip: _____ Occupation: _____
Phone (Home): _____ Phone (Cell): _____
Do You Prefer Text Communication For Appointment Reminders: Yes____ No____
Birthdate: ____/____/____ Height: _____ Weight: _____ Gender: M____ F____
Email Address: _____
Emergency Contact: _____ Phone: _____
Statement of Intoxicants: Please indicate by initialing below if you have consumed any intoxicating substance or non-prescribed drug prior to arriving for your bodywork session.
Yes ____ No____ If Yes please indicate substance consumed: _____

Have you ever received a professional massage? Yes ____ No ____
If Yes, Frequency/Type _____
Date of last massage: _____ What results do you want from your massage?
_____
Are you currently seeing a medical specialist? Yes ____ No____
If Yes please explain: _____
List current medications, including aspirin, ibuprofen, herbs, supplements, etc.: _____
_____
List stress reduction and exercise activities (include frequency): _____
_____

Medical History (Include year and treatment received)

Allergies: _____
Surgeries: _____
_____
Accidents/Injuries/Illnesses: _____
_____
Are you wearing contacts? ___ Dentures? ___ Transdermal patches (nicotine)?___ IV Port?___

Giving 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	
__	__	bone or joint disease	__	__	low back, hip pain
__	__	neck, shoulder, arm pain	__	__	tendonitis
__	__	bursitis	__	__	headaches
__	__	broken/fractured bones	__	__	spasms/cramps
__	__	arthritis	__	__	jaw pain
__	__	sprains/strains	__	__	lupus
__	__	scoliosis	__	__	wrist/hand pain
__	__	disc disease/herniated disc	__	__	leg/foot pain

CIRCULATORY **RESPIRATORY**

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Past	Current	
__	__	heart/vessel conditions
__	__	varicose veins
__	__	high blood pressure
__	__	low blood pressure
__	__	blood clots
__	__	lymphedema
__	__	other: _____

URINARY

Past	Current	
__	__	cystitis
__	__	kidney disease
__	__	urinary tract infections
__	__	other: _____

NERVOUS SYSTEM

Past	Current	
__	__	numbness/tingling
__	__	chronic pain
__	__	herpes/shingles
__	__	fatigue
__	__	sleep disorders
__	__	other: _____

DIGESTIVE

Past	Current	
__	__	chronic/problematic constipation
__	__	chron's disease
__	__	diverticulitis
__	__	irritable bowel syndrome/colitis
__	__	reflux
__	__	other: _____

Past	Current	
__	__	breathing difficulty
__	__	sinus problems
__	__	allergies
__	__	other: _____

REPRODUCTIVE

Past	Current	
__	__	pregnancy, # of weeks _____
__	__	endometriosis
__	__	severe bloating/cramps
__	__	menopausal symptoms
__	__	painful/irregular/absent periods
__	__	other: _____

SKIN

Past	Current	
__	__	rashes/eczema/psoriasis
__	__	athlete's foot
__	__	warts
__	__	allergies
__	__	other: _____

OTHER

Past	Current	
__	__	headaches/migraines
__	__	cancer/tumors
__	__	thyroid issues
__	__	diabetes
__	__	eating disorders
__	__	depression/anxiety
__	__	drug/alcohol/nicotine addiction
__	__	other: _____

CLIENT AGREEMENT

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

_____ _____

SIGNATURE **DATE**