CLIENT HEALTH INTAKE FORM

Name____ Date of Birth__________________

Address_____________________________City__________________State_____Zip________

Home ( )_______________ Work ( )________________ Cell ( )_________________

How did you hear about us? ____________________________ Email______________________

Emergency Contact _____________________________ Telephone ( )____________________

Occupation __________________________

What are your goals for receiving massage therapy?____

□ Yes □ No Have you ever experienced a professional Massage session? How recently?_______

□ Yes □ No Do you frequently suffer from stress?
□ Yes □ No Do you have diabetes?
□ Yes □ No Do you experience frequent headaches?
□ Yes □ No Do you have high blood pressure?
□ Yes □ No Do you suffer from arthritis?
□ Yes □ No Do you have cardiac or circulatory problems?
□ Yes □ No Do you suffer from epilepsy or seizures?
□ Yes □ No Do you have any allergies?
□ Yes □ No Are you on any blood thinners?
□ Yes □ No Have you had disc or spinal problems?
□ Yes □ No Have you had TMJ or jaw pain?
□ Yes □ No Have you ever had blood clots?
□ Yes □ No Do you have varicose veins?

□ Yes □ No Are you wearing contact lenses?
□ Yes □ No Do you have any contagious diseases?
□ Yes □ No Do you have osteoporosis?
□ Yes □ No Do you have athletes foot or warts?
□ Yes □ No Have you had any broken bones in the past 2 years?
□ Yes □ No Have you been in an accident or suffered any injuries in the past 2 years?
□ Yes □ No Do you have tension or soreness in a specific area? Please specify: ____________________________
□ Yes □ No Have you had major surgery? Explain below.
□ Yes □ No Do you have numbness or sciatica?
□ Yes □ No Have you had any benign or malignant tumors?
□ Yes □ No Have you had chest pain or shortness of breath?
□ Yes □ No Are you or have you been pregnant in the past 6 months?
□ Yes □ No Do you have any other medical conditions?

Please List any Medications:
____
____

Comments:
____
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I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 further understand that massage or bodywork 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 that I am aware of. I understand that massage/bodywork 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/bodywork 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 also 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.

Client Printed Name: ____

Client Signature: ________________________________ Date: ________________

Practitioner's Signature: ___________________________ Date: ________________

Consent to Treatment of Minor: By my signature below, I hereby authorize ______________________________ to administer massage/bodywork to my child or dependent as they deem necessary.

Signature of Parent or Guardian ________________________________ Date:________________