

# CLIENT INTAKE & HEALTH HISTORY FORM



Name \_\_\_\_\_ Email \_\_\_\_\_  
 Phone (cell/day) \_\_\_\_\_ DOB \_\_\_\_\_ Age: \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Occupation \_\_\_\_\_ Referred by: \_\_\_\_\_

## Health Information

Are you taking any medications?  yes  no If yes, please list: \_\_\_\_\_

Any allergies? (oils, lotions, nuts, fruits, skin, etc.)  yes  no If yes, please list: \_\_\_\_\_

Are you pregnant?  yes  no If yes, how many months: \_\_\_\_\_ Due date: \_\_\_\_\_

Are you currently under medical supervision or receiving other medical interventions?  yes  no

If yes, please describe: \_\_\_\_\_

	No	Yes		No	Yes		No	Yes
Areas of swelling	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Back / neck problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Tendinitis	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	TMJ disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Neurological condition	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Contagious condition	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo / dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sensation	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>			

Areas of broken skin? (e.g. rash, wounds)  yes  no If yes, where? \_\_\_\_\_

History of joint replacement surgery?  yes  no Which joint(s) ? \_\_\_\_\_

Recent injuries or medical procedures in the past 2 years?  yes  no Please describe: \_\_\_\_\_

Please describe any other injuries or health conditions: \_\_\_\_\_

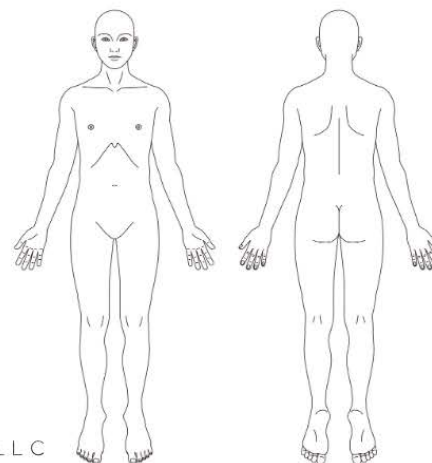
## Massage Information

Have you had professional massage before?  yes  no How recently? \_\_\_\_\_

Reason for seeking massage:  Relaxation  Specific problem *Please indicate any areas of pain, stiffness or discomfort:*

How much pressure do you prefer?  Light  Medium  Firm

Is there anything your massage therapist should know?



*By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.*

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