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 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	☐	☐	Diabetes	☐	☐	Osteoporosis	☐	☐
Autoimmune disorder	☐	☐	Fibromyalgia	☐	☐	Phlebitis	☐	☐
Back / neck problems	☐	☐	Headaches	☐	☐	Sciatica	☐	☐
Bleeding disorders	☐	☐	Heart condition	☐	☐	Seizures	☐	☐
Blood clots	☐	☐	Hypertension	☐	☐	Stroke	☐	☐
Bruise easily	☐	☐	Kidney disease	☐	☐	Tendinitis	☐	☐
Bursitis	☐	☐	Multiple sclerosis	☐	☐	TMJ disorder	☐	☐
Cancer	☐	☐	Neurological condition	☐	☐	Varicose veins	☐	☐
Contagious condition	☐	☐	Neuropathy	☐	☐	Vertigo / dizziness	☐	☐
Decreased sensation	☐	☐	Osteoarthritis	☐	☐			

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

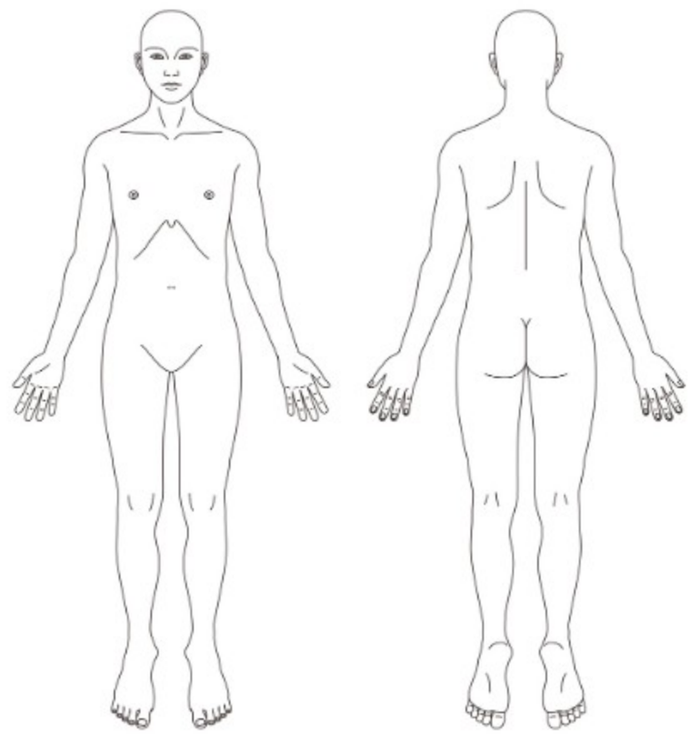
Have you had professional massage before? ☐ yes ☐ no How recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem

_____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of discomfort



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 _____

Therapist Signature _____ Date _____