Confidential Client Intake and Medical History Form

Name:_____ DOB:_____ Date:_____

Occupation:_____ Referred by:_____

Emergency Contact:_____ Emergency Contact Phone:_____

Primary Physician:_____ Date of Last Physical:_____

Massage Experience

Have you had a professional massage? ◯ Yes ◯ No

Health History

(circle if applicable and date if current)

Musculoskeletal
Bone/joint disease
Bursitis/tendonitis
Arthritis/gout
Jaw (TMJ)
Lupus
Spinal problems
Osteoporosis
Migraine/headache

Circulatory
Heart condition
Phlebitis/varicose vein
Blood clot
Blood pressure
Lymphedema
Thrombosis/embolism

Respiratory
Breathing difficulty
Allergies, specify:
_____
Emphysema
Sinus Problems

Nervous System
Shingles
Numbness/tingling
Pinched Nerve
Chronic Pain
Paralysis
Multiple Sclerosis
Parkinson's Disease

Reproductive
Pregnant, stage:____
Ovarian problems
Prostate problems

Skin
Allergies, specify:
_____
Rashes
Cosmetic surgery
Athlete's foot
Herpes/cold sore

Digestive
IBS
Bladder problems
Kidney problems
Colitis
Chrohn's Disease
Ulcers

Psychological
Anxiety/stress
Depression

Other
Cancer/tumor
Diabetes
Drug/Alcohol use
Tobacco use
Contact lenses
Hearing aids

Any other medical condition:_____

Please explain:_____

List medications you are currently taking:_____

(continued on back)

Current Health Form

What is your reason for your initial visit?_____

Are you experiencing discomfort, stiffness, pain? If yes, where?_____

What are your exercise habits?_____

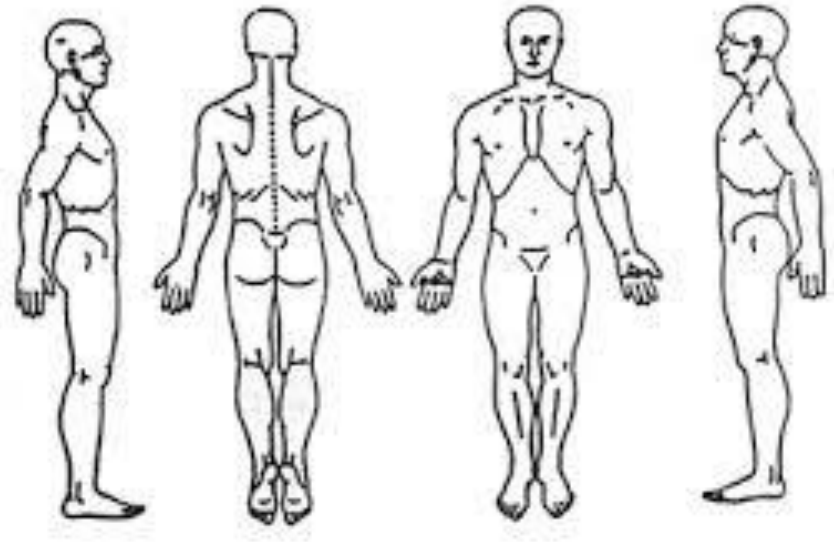
Have you recently had surgery, injury, or areas of inflammation?_____

List allergies to oils, lotions, creams, etc:_____

I,_____(print name) understand that the massage 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 therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 therapists 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 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature:_____Date:_____

Please circle any areas of discomfort or areas you would like the therapist to focus on



Thank you!