



## Confidential Health Intake Form

Name _____ Email _____		D.O.B: ____ / ____ / ____
Address _____		Day Phone: (    ) _____
City _____	State _____ Zip _____	Cell Phone: (    ) _____

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Physician/Healthcare Provider: \_\_\_\_\_ Healthcare Provider's Phone \_\_\_\_\_

Have you received a professional massage before today? **Yes** or **No**

Are you currently taking any pain medication or physician prescribed medications? If yes, please list below:

Medications:	Prescribed for:

Have you had any **major surgeries or injuries** that your massage practitioner needs to be aware of? **Yes** or **No**

Surgery:	Approx.Date

Major Injuries:	Approx. Date

Do you have allergies to nuts, lotions, oils or creams? **Yes** or **No**

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

- If you wear any of the following, **please circle**:

Contact lenses    Dentures    Hearing aids    Hairpiece or wig    Body piercing

- If you have any of the following medical devices, **please circle**:

Insulin pump    Pacemaker    Temporary IV    Bone pins/s    Spinal rods    other:\_\_\_\_\_



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Below is a list of medical conditions. Keep in mind that some medical conditions may require you to have a physician's release form to receive massage. In some situations massage may not be advisable, but in most cases a session can be modified to suit your needs.

- **If you are currently dealing with any of the conditions listed below, place a check in the appropriate area:**

### Blood, Heart and Circulatory

Anemia \_\_\_  
 Aneurysm \_\_\_  
 Arteriosclerosis \_\_\_  
 Bruise Easily \_\_\_  
 Circulatory Disorder \_\_\_  
 Congestive Heart Failure \_\_\_  
 Edema \_\_\_ Clotting Disorder \_\_\_  
 Heart Attack \_\_\_  
 High Blood Pressure \_\_\_  
 Irregular Heart Palpitations \_\_\_  
 Low Blood Pressure \_\_\_  
 Lymphedema \_\_\_  
 Stroke \_\_\_ Mini \_\_\_ Major \_\_\_  
 Valve Disorder \_\_\_ Varicose veins \_\_\_

### Auto Immune, Endocrine, & Nervous System

Diabetes \_\_\_ Type I \_\_\_ or Type II \_\_\_  
 Fibromyalgia \_\_\_  
 Lupus \_\_\_  
 Multiple Sclerosis \_\_\_  
 Neuropathy \_\_\_  
 Parkinson Disease \_\_\_  
**Respiratory**  
 Asthma \_\_\_  
 Bronchitis \_\_\_  
 Chronic Cough \_\_\_  
 Emphysema \_\_\_  
 Seasonal Allergies \_\_\_  
 Shortness of Breath \_\_\_  
 Pneumonia \_\_\_

### Bone, Joint & Muscle

Bulging Disc/s \_\_\_  
 Carpal Tunnel Syndrome \_\_\_  
 Osteoarthritis \_\_\_ Location \_\_\_\_\_  
 Rheumatoid Arthritis \_\_\_

### **Chronic Pain**

Back \_\_\_ Hip/s \_\_\_ Knees \_\_\_  
 Neck \_\_\_ Elbow \_\_\_ Wrist/s \_\_\_  
 Shoulder joints \_\_\_

### **Do you suffer from:**

Headaches \_\_\_ Migraine \_\_\_ Tension \_\_\_  
 Muscle cramps/spasms \_\_\_ Vertigo \_\_\_

### **Skin**

Eczema \_\_\_ Bruises \_\_\_ Cuts/Scrapes \_\_\_

### **Cancer**

Breast \_\_\_ Date of last tx: \_\_\_\_\_  
 Colon \_\_\_ Date of last tx: \_\_\_\_\_  
 Skin \_\_\_ Date of last tx: \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Have you had cancer within the last five years? Any metastasis? \_\_\_

### **Viral**

Herpes \_\_\_ I \_\_\_ II \_\_\_  
 Hepatitis \_\_\_  
 Shingles Outbreak \_\_\_  
 Warts \_\_\_ Location \_\_\_\_\_

### **Women Only:**

Pregnant? \_\_\_ Due Date: \_\_\_\_\_  
 Fibroid Tumors \_\_\_  
 Menopausal Symptoms \_\_\_  
 Painful Menses \_\_\_  
 Endometriosis \_\_\_  
**Men Only:** Prostate Problems \_\_\_

**Is there any medical condition *not* listed above that your massage therapist should be aware of?  
 If yes, please list:**

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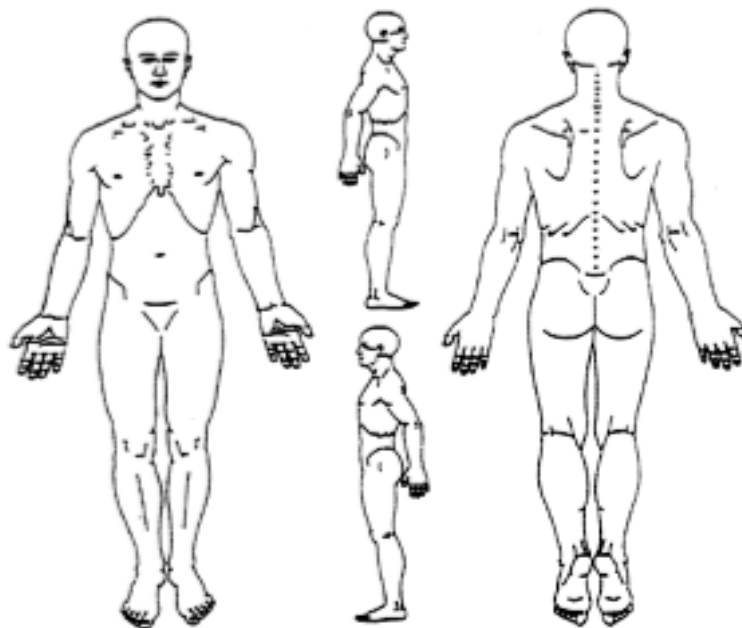
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Please shade the area/s of pain you feel today or would like the most focus:



*Please be aware that depending on the length of the massage session and the technicality of the work your massage therapist may not be able to address all areas in one session.*

List physical activities you participate in regularly \_\_\_\_\_

What movements or activities are limited? \_\_\_\_\_

Describe the events of the injury or accident: \_\_\_\_\_

What other types of wellness treatments are you receiving & by whom (acupuncture, physical therapy, chiropractic, naturopathic): \_\_\_\_\_

What is your main activity at work?

On phone \_\_\_\_\_ Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Computer work \_\_\_\_\_ Driving car \_\_\_\_\_ Walking \_\_\_\_\_ Heavy lifting \_\_\_\_\_

Other \_\_\_\_\_

What would you most want to get out of you session(s)? \_\_\_\_\_

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

Massage Therapist Signature: \_\_\_\_\_ Date \_\_\_\_\_



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