Massage Health Intake Form

Name:_____Date:_____Email:_____
Home Address:_____Phone #:_____
Have you ever received a professional massage?___No____Yes. If yes, date of last massage_____
Are you currently seeing a health care practitioner?___No___Yes. If yes, please explain_____
_____
List current medications, herbals & supplements and reason for use. Please include OTCs such as aspirin, ibuprofen, Claritin, etc._____
_____
Previous surgeries (in last 2 years)_____
Previous Accidents:_____

HEALTH HISTORY

MUSCULOSKELETAL:
___Bone or Joint Disease
___Tendonitis / Bursitis
___Broken / Fractured Bones
___Arthritis / Gout
___Jaw pain / TMJ
___Sprains / Strains
___Low Back, Hip, Leg Pain
___Neck, Shoulder, Arm Pain
___Headaches, Head Injuries
___Spasms / Cramps
___Other:_____

CIRCULATORY:
___Heart Condition
___Varicose Veins / Phlebitis
___Blood Clots
___High / Low Blood Pressure
___Lymphedema
___Thrombus / Embolism
___Cardiac Arrhythmia

RESPIRATORY:
___Breathing Difficulty / Asthma
___Emphysema
___Allergies: Specify:_____

NERVOUS:
___Shingles
___Numbness / Tingling
___Pinched Nerve
___Other:_____

REPRODUCTIVE:
___Pregnant: Trimester_____

SKIN:
___Allergies: Specify_____
___Rashes
___Athlete's foot
___Warts
___Cellulitis
___Other:_____

OTHER:
___Cancer / Tumors
___Diabetes
___Chronic Fatigue
___Chronic Pain
___Sleep Disorders
___Hyperthyroid
___Bladder / Kidney Ailment
___Migraines / Headaches
___Anxiety / Stress Syndrome
___Contact Lenses
___Stroke
___Fever
___Sensitivity of carotid sinus
___Other:_____

Client signature:_____Date:_____
Therapist Signature:_____Date:_____