- MASSAGE THERAPY & HEALING ARTS -

Confidential Health History Intake and Consent Form

Client Information

Name _____ Date _____

Address _____ Phone _____

Occupation _____ Date of Birth _____

Email _____ Referred by _____

Emergency Contact Name and Phone _____

Massage Session Information

Have you ever received a professional massage? ☐ Yes ☐ No Date of last massage: _____

What are your goals in seeking massage therapy?

_____

What type of pressure do you prefer? ☐ **Light** ☐ **Moderate** ☐ **Deep**

Would you like anything omitted from your treatment? Special needs, cautions, contraindications?

_____

List any stress reduction, exercise activities & frequency:

_____

Are you currently receiving medical, chiropractic care, or physical therapy? ☐ Yes ☐ No

If yes, what for/how often? _____

Dr. or PT's Name and Phone: _____

Are you taking any blood thinners (Aspirin, Ibuprofen, Coumadin, Warfarin)? ☐ Yes ☐ No

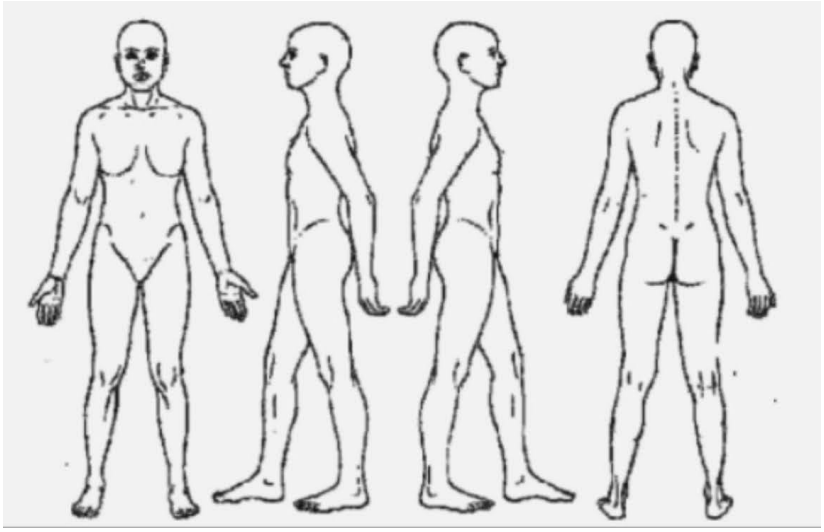
List current medications including herbs and supplements:

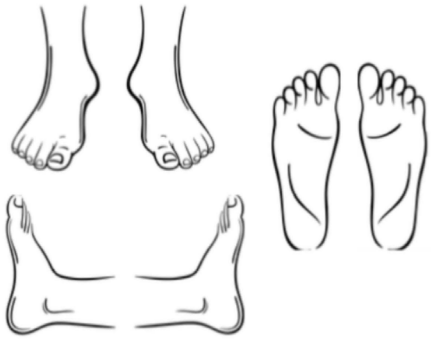
_____

Do you wear contacts? ☐ Yes ☐ No	Dentures? ☐ Yes ☐ No
Transdermal patches (nicotine/other) ☐ Yes ☐ No	IV port? ☐ Yes ☐ No
Topical Hormone/pain cream? ☐ Yes ☐ No	Pregnancy - if current, # of weeks? _____

Please indicate areas (circle or x) of pain or discomfort and briefly describe:

_____





Injuries/accidents/illness still affecting you:

_____

Have you had a recent surgery? ☐ Yes ☐ No If yes, when? _____
Prior Surgeries:

_____

Surgeon's name and Phone _____

Please mark any of the following that you now have or have had.

☐ Allergies (specify): _____

MUSCULOSKELETAL:

☐ Lupus
☐ Bone/Joint Disease
☐ Bursitis
☐ Tendonitis
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Migraines/Headaches
☐ Head Injury
☐ Spasms/Cramps
☐ Broken bones/Fractures
☐ Sprains/Strains
☐ Low Back Pain
☐ Arthritis
☐ Scoliosis
☐ Jaw Pain (TMJ)
☐ Neck Pain
☐ Shoulder Pain
☐ Arm Pain
☐ Hip Pain
☐ Spinal Problems
☐ Disc Injuries

CIRCULATORY:

☐ Heart Condition
☐ Blood Clots
☐ High/Low Blood Pressure
☐ Thrombosis/DVT
☐ Lymphedema
☐ Varicose Veins

SKIN:

☐ Allergies
☐ Warts
☐ Rashes
☐ Herpes/Cold Sores
☐ Athlete's Foot

NERVOUS SYSTEM:

☐ Numbness/Tingling ☐ Herpes/Shingles ☐ Sleep Disorders

☐ Chronic Pain ☐ Fatigue ☐ Other:_____

DIGESTIVE/URINARY:

☐ Constipation ☐ Diverticulitis ☐ Kidney/Bladder Infection

☐ Gas/Bloating ☐ Irritable Bowel Syndrome

RESPIRATORY

☐ Asthma ☐ Breathing Difficulty ☐ Allergies

☐ Sinus Problems ☐ Other:_____

REPRODUCTIVE & PMS:

☐ Bloating ☐ Mood Swings ☐ Painful Periods

☐ Cramps/Pain ☐ Breast Tenderness ☐ Irregular Periods

☐ Pre-menopausal symptoms ☐ Menopausal symptoms ☐ Absent Periods

OTHER:

☐ Cancer ☐ Tumor ☐ Diabetes

Any other health concerns you think I should know about?

Please read each section and mark:

- ☐ I have completed this form and stated all medical conditions I am aware of to the best of my knowledge and will update my massage therapist of any change in my physical health.
- ☐ It is my choice to receive massage therapy. I realize that the massage is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasms and/or pain. I agree to openly communicate with my practitioner during my session (ex: comfort on table, pressure, safety, etc.).
- ☐ I understand that a massage therapist cannot diagnose illness, disease, or any medical, physical, or emotional disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform any spinal thrust manipulation. I am responsible for consulting a qualified physician or physical therapist for any physical ailments that I have.
- ☐ I understand that massage therapy is a therapeutic health aide and is non-sexual.
- ☐ I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.
- ☐ I agree to the following Cancellation Policy: I will cancel my scheduled appointment at least 24 hours in advance. I understand that less than 24-hour notice will result in billing for my dedicated appointment time.

Signed _____ Date _____