Massage Intake Form

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Marital Status: □ Single □ Married

Children's Names and Ages: _____

Name of Spouse/Significant Other: _____

Preferred Appointment Day and Time: _____

Referred By: Name: _____

□ Touch of Health □ Ad □ Sign □ Website □ Other: _____

What are your long-term massage goals? _____

_____

What are your goals for this treatment? _____

_____

Present Symptoms: What is your major complaint or condition you want to improve? _____

_____

What activities and products have you used to address this condition? _____

_____

What activities or products aggravate the condition? _____

_____

What activities or products improve the condition? _____

_____

Are you under medical/therapeutic treatment? □ Yes □ No

If yes, for what condition? _____

_____

Please list your care provider's name and phone number? _____

List any medications (including aspirin) and nutritional supplements you are taking: _____

_____

Specify any known allergies: _____

_____

Please list any additional comments regarding your-self care or general well-being: _____

_____

Health History

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal
□Headaches
□Joint Stiffness/swelling
□Spasma/cramps
□Broken/fractured foot
□Strains/sprains
□Back, hip pain
□Shoulder, neck, arm, hand pain
□Leg, foot pain
□Chest, ribs, abdominal pain
□Problems walking
□Jaw pain/TMJ
□Tendonitis
□Bursitis
□Arthritis
□Osteoporosis
□Scoliosis
□Bone or joint disease
□Other: _____

Circulatory and Respiratory
□Dizziness
□Shortness of breath
□Fainting
□Cold feet or hands
□Cold sweats
□Swollen ankles
□Pressure sores
□Varicose veins
□Blood clots
□Stroke
□Heart condition
□Allergies
□Sinus problems
□Asthma
□High blood pressure
□Low blood pressure
□Lymphedema
□Other: _____

Skin
□Rashes
□Allergies
□Athlete's Foot
□Warts
□Moles
□Acne
□Cosmetic Surgery
□Other: _____

Digestive
□Nervous stomach
□Indigestion
□Constipation
□Intestinal gas/bloating
□Diarrhea
□Diverticulitis
□Irritable bowel disease
□Crohn's Disease
□Colitis
□Adaptive aids
□Other: _____

Nervous System
□Numbness/tingling
□Twitching of face
□Fatigue
□Chronic pain
□Sleep disorders
□Ulcers
□Paralysis
□Herpes/shingles
□Cerebral Palsy
□Epilepsy
□Chronic Fatigue Syndrome
□Multiple Sclerosis
□Muscular Dystrophy
□Parkinson's disease
□Spinal cord injury
□Other

Reproductive System
□Pregnancy:
□Current □Previous
□PMS
□Menopause
□Pelvic Inflammatory Disease
□Endometriosis
□Hysterectomy
□Fertility concerns
□Prostate problems

Other
□Loss of appetite
□Forgetfulness
□Confusion
□Depression
□Difficulty concentrating
□Drug use _____
□Alcohol use _____
□Nicotine use _____
□Caffeine use _____
□Hearing impaired
□Visually impaired
□Burning upon urination
□Bladder infection
□Eating disorder
□Diabetes
□Fibromyalgia
□Post/Polio Syndrome
□Cancer
□Infectious disease (please list)
_____
□Other congenital or acquired disabilities (please list) _____
_____
□Surgeries _____
□Other: _____

For clients who need mobility assistance, please give your height: _____ weight: _____

Please list any additional comments regarding your health and well-being _____
_____
_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____