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CLIENT INTAKE FORM

Some of the benefits of massage therapy, such as increased circulation, can aggravate certain medical conditions like high blood pressure. Clients with specific medical conditions are better served with a "lighter" massage, while others are advised against any at all. In order to maximize the safety and effectiveness of your massage, please take the time to carefully fill out this questionnaire. ALL INFORMATION ON THIS FORM IS HELD IN STRICTEST CONFIDENCE.

Name: ______________________________

Address: ______________________________

City, State: ______________ Zip: ______________

Home Phone: ______________ Work Phone: ______________

Occupation: ______________ Social Security #: ______________

Date of Birth: ______________ Age: ______ M ☐ F ☐ Marital Status: ______ No. of Children: ______

Height: ______ Weight: ______ Referred by: ______________

BP (Blood Pressure): ______________________________

MEDICAL HISTORY:

- ☐ Heart Condition
- ☐ Allergies/Skin Problems
- ☐ Arteriosclerosis
- ☐ TMJ Dysfunction
- ☐ Arthritis
- ☐ Frequent Headaches
- ☐ Epilepsy
- ☐ Varicose Veins/Phlebitis
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Asthma
- ☐ HIV/Aids
- ☐ Spinal Injury
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Tight Shoulder
- ☐ Stiff Neck
- ☐ Joint Pain
- ☐ Sciatic Pain
- ☐ Dizziness
- ☐ Stroke
- ☐ Seizure
- ☐ Poor Circulation
- ☐ Tendonitis
- ☐ Diabetes
- ☐ Herniated Disk
- ☐ Easy Bruising
- ☐ Sinusitis
- ☐ Osteoporosis

Are you currently under a Physician's care? ☐ Yes ☐ No Dr's Name: ______________

Are you taking any medications? ☐ Yes ☐ No If yes, which? ______________

Are you wearing? ☐ Contact lenses ☐ Dentures ☐ Hearing Aid

Are you pregnant? ☐ Yes ☐ No If yes, what stage of pregnancy? ______________

Do you have an IUD? ☐ Yes ☐ No Do you have pain which radiates down legs or arms? ☐ Yes ☐ No

Have you undergone any recent surgery? Please describe: ______________

____

Do you have any previous fractures or injuries? ☐ Yes ☐ No Please describe: ______________

____

Are there any other medical conditions that you feel we should be aware of? Please describe: ______________

____

How hard do you exercise? ______________________________

Have you had a professional massage before? ______________________________

I have completed this form to the best of my knowledge. I understand that massage therapy is designed to be a health aid and not a substitute for care by a physician.

Signature ______________________ Date ______________

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CASE HISTORY

PRESENT SYMPTOMS:

1. Major Complaint: ____________________

____

2. Minor Complaints: ____________________

____

3. When did you first notice major complaint? ____________________
4. What brought it on? ____________________
5. What activities aggravate condition? ____________________
6. Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and Goes
7. Is this condition interfering with your ❑ Work ❑ Sleep ❑ Daily Routine
8. What have you done to get relief? ____________________
9. Has there been a medical diagnosis? ❑ Yes ❑ No Whom: ____________________
   Address: ____________________
   Phone: ____________________ Fax: ____________________
   X-Rays: ____________________ MRI: __________ Blood Work: ____________________

PAST HISTORY:

10. Have you had a similar problem before? If yes, When? ____________________
11. What caused those episodes? What relieved them? ____________________
12. Did they disable you? ❑ Yes ❑ No Prevent you from working? ❑ Yes ❑ No
    Hospitalize you? ❑ Yes ❑ No
13. What was previus diagnosis? ____________________
14. What were the treatments? ____________________
15. Did they help? ❑ Yes ❑ No
16. Name of attending Physician:
    Address: ____________________
    Phone: ____________________ Fax: ____________________
17. Are you on any medications? ❑ Yes ❑ No If yes, list them:s
18. Ate you taking any of the following? ❑ Laxatives ❑ Aspirins ❑ Sleeping Pills ❑ Insulin ❑ Vitamins ❑ Minerals ❑ Herbs ❑ Sedatives
19. Have you ever:
    Had any operations? ❑ Yes ❑ No Describe briefly ____________________
    Broken any bones? ❑ Yes ❑ No Describe briefly ____________________
    Been in an accident? ❑ Yes ❑ No If yes, did you receive a whiplash? ____________________

FAMILY HISTORY:

20. Has any disease afflicted one or more than one member of your family? ____________________
21. Was it fatal? ❑ Yes ❑ No