

Confidential Health Intake Form

Name _____ Referred By _____

Phone (Primary) _____ (Other) _____ Email _____

Address _____ City _____ Zip _____

Ever had a massage? **Yes No** When was the last one? _____ DOB ____/____/____

Occupation _____ Are you Right handed or Left? **R L Ambi**

Please check if you have or have had any of the following with in the last 10 years

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Back Pain:
<input type="checkbox"/> Upper <input type="checkbox"/> Mid <input type="checkbox"/> Low | <input type="checkbox"/> Car Accident
<input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Neck Pain
<input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stress
<input type="checkbox"/> Depression |
| <input type="checkbox"/> Pain Down Legs (Sciatica) | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Skin disorders/Rashes:
<input type="checkbox"/> Athletes foot <input type="checkbox"/> Other | <input type="checkbox"/> Foot Pain
<input type="checkbox"/> TMJ | <input type="checkbox"/> Tendonitis
<input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis
<input type="checkbox"/> Herniated Disk |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Swelling | <input type="checkbox"/> Arthritis |

Exercise regularly? **Yes No** Stretch regularly? **Yes No** Any chance of pregnancy? **Yes No**

Ever been sore after a massage? **Yes No N/A** Being treated by a doctor/therapist? **Yes No**

If so, for what? _____ Medications _____

Anywhere sensitive or ticklish? _____ Are you sensitive to heat? **Yes No Don't know**

What pressure do you prefer? **Light Medium Medium-Deep Deep Don't know**

Depending of necessity, may I use essential oils and/or muscle comfort creams to aid the therapeutic process? **Yes No** May I use Hot stones? **Yes No**

What results would you like from this massage? _____

Consent for body work on: **All Areas Below**

Back Gluteals Legs Feet Arms Hands Neck Face Head

Please feel free to specifically request work on any area, even if it is not indicated here on the form _____

I understand that it is my choice to receive Massage Therapy. I understand that Massage Therapy is a non-sexual therapeutic massage given with the aim at reducing stress and relief for minor tension, pain, or spasm. To the best of my knowledge I have provided accurate information concerning my personal health. Massage Therapists do not diagnose or treat medical conditions. Any health concerns should be brought to the attention of your health care provider. I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

Signature _____ Date ____/____/____