Massage Intake Form
Client Health History

Your Name:___________________________
Address:______________________________
____
____
Phone: (home)_________________________
(other)_________________________
Date of Birth:________________ Age:______
Occupation:____________________________

Reason for Visit:______________________
____

Doctor's Name:_________________________
Doctor's Address:______________________
____
____
Who referred you to Emily?
____

Have you had massage before?
yes no

General Health:_________________________

Current Health Concerns

What are your main health concerns? List in order of importance to you.

Concern	**1.**	**2.**	**3.**	**4.**
Details	THERAPIST	USE	ONLY	

Medical Conditions

Please indicate any serious illness, trauma, surgeries or hospitalizations.

Medical Condition	**Date Diagnosed**	**Current Condition**	**Symptoms**	**Current Treatment**
		Yes No		
		Yes No		

Allergies and Sensitivities

Including medications, food, animals, chemicals, fragrances, and environmental triggers.

ALLERGY // **Severity of Reaction** (hives/rash, headache, anaphylaxis)

Current Medications

Including prescriptions, over the counter medications, vitamins and supplements.

Medication/Supplement	Length of time on this medication.	Prescribing Physician	Condition it treats

SYSTEMS OVERVIEW

Respiratory
- Cough
- Difficulty Breathing
- Shortness of Breath
- Nasal Congestion
- Sinus Pressure
- Bronchitis
- Asthma
- Emphysema
- Smoker (past / present)
- Pneumonia

Arthritis
- Type?

Where:_________________
- Family History?

Cardiovascular
- High Blood Pressure
- Low Blood Pressure
- Angina
- Heart Attack
- Heart Failure
- Heart Disease
- Heart Palpitations
- Chest Pains
- Phlebitis, varicose veins

Hearing/Vision
- Hearing impairment
- Visual impairment

Headaches
- Type?

Frequency:

Central Nervous System
- Epilepsy
- TIA/Stroke
- Multiple Sclerosis
- Parkinsonism

Skin
- Infectious Conditions
- Warts, Herpes
- Eczema
- Psoriasis
- Itching
- Rashes/Hives
- Acne
- Skin Boils

Diabetes
- Type?

Year Diagnosed: _________

Exercise Information

How often do you exercise weekly? ____

What form of exercise? ____

How long do you exercise? ____

Digestion/Urination

- Abdominal Pain
- Nausea, Vomiting
- Gas
- Difficult Digestion
- Fatty Foods Aggravate
- Diarrhea
- Constipation
- Irritable Bowel Syndrome
- Straining
- Crohn's/ Colitis
- Ulcer
- Urinary Problems
- Night Urination
- Burning on Urination
- Bedwetting
- Blood in Urine
- Bladder/Kidney infection
- Kidney disease
- Kidney or Gallstones

Cancer

Type?
Year Diagnosed: ________
Current/Past treatment:
- Chemotherapy
- Radiation

Women

- Pregnant? Due: ______
- High Risk Pregnancy
- Breast Feeding
- Endometriosis
- Breast Pain
- Lump in Breast
- Menopause Issues
- Menstruation Issues

Altered Sensation?

Where? _______________

Musculoskeletal (C-Current; P-Past)

C	P	Neck Problem	C	P	Hip Problem
C	P	Shoulder Problem	C	P	Knee Problem
C	P	Arm Problem	C	P	Ankle Problem
C	P	Wrist Problem	C	P	Foot Problem
C	P	Hand Problem			
C	P	Mid Back Problem			Bone or Joint Pains
C	P	Low Back Problem			Joint Swelling

Other Health Care

C	P	Physiotherapy
C	P	Chiropractic
C	P	Psychotherapy
C	P	Medical Specialist
C	P	Other

Special Considerations

pacemaker	breast implants
rods, pins, wires	medical patch
artificial joints	drug or chemo port
cane, walker use	artificial valve
wheelchair use	crutch use

I certify that the information given in this form is true and accurately reflects my past and present health status.

Client's Signature ___________________________ Date _________________________