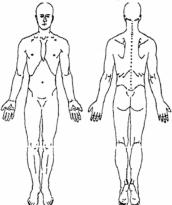


Client Health Intake Form

Name:			Date:
Address:			
City:	Sta	te:	_ Zip:
Phone:	Emai	l Address:	
Occupation:	Date	of Birth: _	//
Would you like to be put on the monthly email list to receive special offers? \Box Yes \Box No			
How did you hear about me?			
Have you ever received massage before? 🖵 Yes 🛛 No			
If yes, what kind?			
Please list any activities/exercise that you do regularly (At least once a week):			
Are you currently under the care of a healthcare professional? 🖵 Yes 🛛 No			
If yes, please provide doctor's name and condition:			
Are you currently taking any medications? 🖵 Yes 🛛 No			
If yes, please list and give reason	n for medication:	. <u></u>	
Are you allergic or sensitive to anything? 🖵 Yes 🛛 🖵 No			
If yes, please list			
Do you wear: Contacts 🖵 Yes	🖵 No	Dentures [Yes No
	Hair piece 🖵 Yes	🗖 No	
What brought you in today?			
What are your long term treatment goals?			

Please fill out other side

Please use the diagram below to mark the areas where you would like your therapist to focus :



Within the last 2 years, have you experienced discomfort having to do with any of the following? Muscular/Skeletal

□ Sprains/Strains □ Broken bones □ Tendonitis □ Bursitis □ Arthritis □ Gout

Jaw Pain 🗅 Lupus 🗅 Other:_____

Circulatory

□ Phlebitis □ Varicose Veins □ Blood Clots □ High/Low Blood Pressure

Lymphedema 🗅 Thrombosis/Embolism 🗅 Other:

Respiratory

Asthma D Emphysema D Sinus Problems D Other:

Nervous

□ Shingles □ Pinched Nerve □ Numbness/Tingling □ Other:

Reproductive

□ Pregnant (Weeks) □ Trying to Become Pregnant □ Postpartum (Weeks) □ Irregular cycles □ Severe Menstrual Symptoms □ Other:

Skin

Rashes Athletes Foot/ fungal infections Herpes/ cold sores Eczema Warts

🗅 Psoraisis 🗅 Dermatitis 🖵 Cuts/Bruises 📮 Other:

Digestive

□ Irritable Bowel Syndrome □ Ulcers □ Constipation □ Other:

Other

□ Cancer/tumors □ Bladder/kidney problems □ Diabetes □ Chronic fatigue

□ Drug/Alcohol/Caffeine/Tobacco use □ Chronic pain □ Sleep Disorders

🗆 Migraines/Headaches 🗳 Anxiety disorder 📮 Depression 📮 Surgery 📮 Other:

Is there anything else your therapist should know?

I give permission for my massage therapist to use techniques within her scope of practice which she deems appropriate for my treatment.

I understand that massage therapy is strictly therapeutic and therefore strictly non-sexual. I understand that if I behave inappropriately during the session, the massage therapist has the right to end the massage, and I will be charged the full amount for the appointment.

I understand that while therapeutic, massage is not a replacement for medical care, diagnosis or treatment. I agree to give 24 hours notice if I need to cancel an appointment. If I will be late, I agree to call and let my therapist know, or be charged a no-show fee.

I have answered each of these questions to the best of my knowledge and if anything negative occurs due to omission on my part, my massage therapist is not at fault.

Signature: _____ Date: _____

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