

Preferred Massage - Client Health History Intake

Please take a moment to answer the following questions. The information you provide will be used to customize your session to your needs and exclude any techniques that may be medically unsuitable for you.

Name _____ Date of Birth _____ Male Female

Address _____ City/State/Zip _____

Phone Numbers: (Home/Cell) _____ (Work) _____ Email: _____

Employer: _____ Occupation _____

Physician _____ Chiropractor _____ Referred By: _____

Emergency Contact & Phone: _____

Current Medications/OTC/Supplements & WHY: _____

Please answer the following to the best of your knowledge.

1. Have you had a professional massage before? Yes No
2. Do you have allergic reactions to oils, lotions, or other substances put on your skin, or to any nuts? Yes No
3. Do you have any particular goals for this massage session? _____
4. If you are currently under medical supervision, please explain _____
5. Please check any condition/symptom listed below that applies to you:

Musculoskeletal System

- Artificial Joint
- Baker's Cyst
- Bursitis
- Fibromyalgia or CFS
- Muscular Dystrophy
- Osteoarthritis
- Osteoporosis
- Plantar Fasciitis
- Rheumatoid Arthritis
- Tendonitis
- Whiplash
- Other _____

Nervous System

- Alzheimer's
- Herpes Zoster/Shingles
- Multiple Sclerosis
- Parkinson's Disease
- Peripheral Neuropathy
- Seizures
- Spinal Cord Injury
- Numbness
- Other _____

Circulatory System

- Atherosclerosis
- Deep Vein Thrombosis (DVT)
- Heart Attack
- High Blood Pressure
- Leukemia
- Low Blood Pressure
- Stroke
- Varicose Veins
- Other _____

Digestive System

- Crohns
- IBS
- Ulcers
- Ulcerative Colitis
- Other _____

Lymph/Immune System

- Allergic Reactions
- Chronic Fatigue
- HIV/AIDS
- Lupus
- Lymphoma
- Other _____

Respiratory System

- Asthma
- Chronic Bronchitis
- Sinusitis
- Other _____

Integumentary System (Skin)

- Athlete's Foot
- Boils
- Burns
- Cold Sore/Herpes
- Dermatitis
- Impetigo
- Open Sores/Wounds
- Psoriasis
- Rashes
- Warts
- Other _____

Miscellaneous Conditions

- Cancer
- Depression
- Diabetes
- Easy Bruising
- Headaches
- Migraines
- Numbness
- Pregnant
- Other _____

6. Please list any accidents or operations you have had and dates: _____

7. Please list any Sports/Regular Physical Activities **you do**:

- | | | | |
|-----------|------------|--------------|--------------|
| Cards | Running | Tennis | Quilting |
| Gardening | Volleyball | Walking | Swimming |
| Golf | Bowling | Lift Weights | Other: _____ |

8. Please circle the level of physical activity you do:

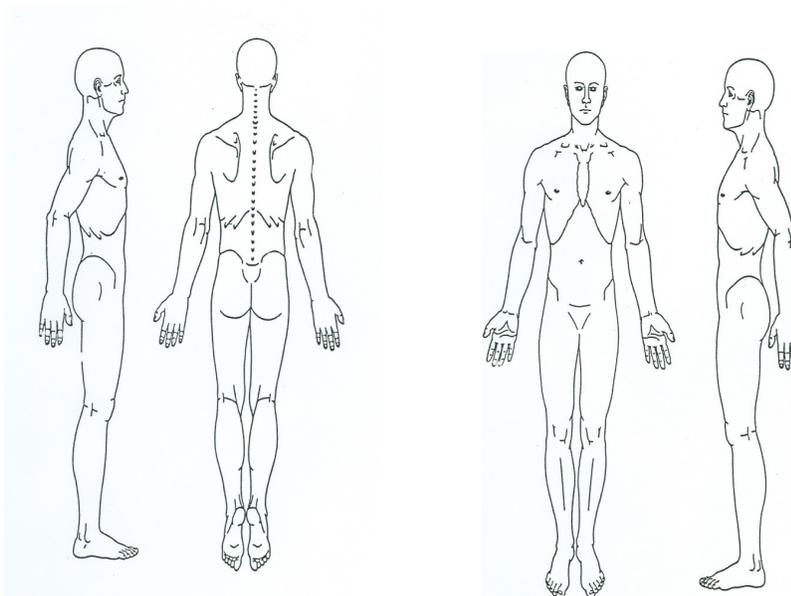
None

Light

Moderate

Heavy

9. Please mark on the body forms with an "X" where you are experiencing any tension, stiffness or other discomfort. Please describe the sensation (burning, stinging, aching, pins-n-needles, etc.): _____



_____ (initials) I understand the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity, and flexibility. I understand a massage therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch. I understand massage therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep the massage therapist informed of any changes in my health and medications in the future. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session. Consent for Treatment: I authorize the performance of massage therapy techniques and procedures and understand that I will receive them from a Certified Massage Therapist at CEC Consultants, Inc. dba Preferred Massage. I understand that payment is expected at the time of service.

_____ (initials) My appointment time has been reserved for me. In the event that I may have to cancel an appointment, I will kindly give a 24-hour notice to the facility. I understand that if a 24-hour notice is not given, I may be charged for the scheduled appointment. If I arrive late to my appointment, I understand that my massage will conclude at my scheduled time to respect the practitioner's client schedule.

Signature _____ Date _____

I understand that I may be refused treatment if I appear obviously intoxicated or under the influence of drugs.

Signature _____ Date _____