

## Client Intake and Health History Form

Please complete this form to the best of your knowledge and print legibly. All information and may only be released to a third party upon the client's written consent

### Personal Information

Name: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Telephone Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

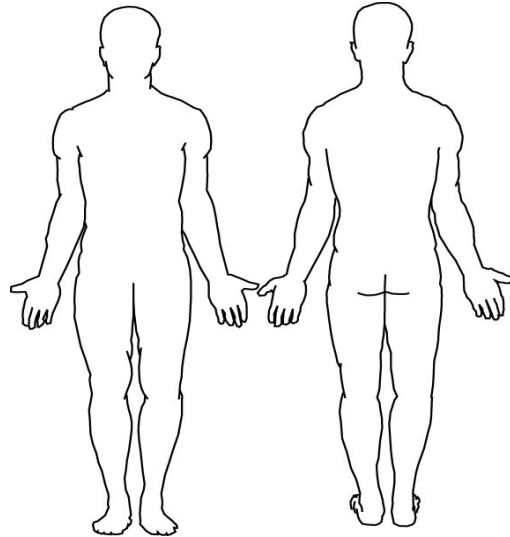
Address: \_\_\_\_\_

Reason For Seeking Massage: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please indicate current problem areas by using the appropriate symbols

Pain	P
Stiffness	Sti
Numbness	N
Tingling	T
Burning	Bu
Stabbing	Sta
Aching	A
Scars	Sc
Bruises	Br
Wounds	W



### Consent To Treatment

I \_\_\_\_\_, consent to massage therapy treatments as described by my therapist. I verify, to the best of my knowledge, that the information given on this form and the following form, on reverse, are true and accurately reflect my past and present health status.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Health History :

Please check the condition(s) which you are currently experiencing or have experienced recently.

### Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Heart Disease
- Stroke
- Varicose Veins
- Phlebitis
- Bruise Easily
- Chronic Congestive Heart Failure
- Presence Of A Pacemaker Or Similar Device

### Respiratory:

- Asthma
- Emphysema
- Sinusitis
- Bronchitis
- Shortness of Breath
- Tuberculosis
- Chronic Cough

### Skin:

- Eczema
- Psoriasis
- Fungal Infections
- Herpes Simplex
- Other Skin Conditions  
Specify \_\_\_\_\_
- Known Allergies  
Specify \_\_\_\_\_

### Nervous:

- Multiple Sclerosis
- Seizures
- Altered Sensation
- Carpal Tunnel Syndrome
- Epilepsy

### Muscle/Joint:

- Arthritis  
Type \_\_\_\_\_  
Location \_\_\_\_\_
- Fibromyalgia
- Osteoporosis
- Scoliosis
- Gout
- Nerve Pain/Damage
- Other \_\_\_\_\_

### Women:

- Pregnant  
Due Date \_\_\_\_\_
- Caesarian Section
- Painful Menstruation
- Endometriosis
- Menopausal Symtoms
- Other \_\_\_\_\_

### Digestive:

- Ulcerative Colitis
- Crohn's Disease
- Gall Stones
- Liver Disease
- Constipation
- Diarrhea
- Diverticulitis
- Ulcer
- Other \_\_\_\_\_

### Other:

- Diabetes
- HIV/AIDS
- Cancer
- Hepatitis
- Chronic Fatigue Syndrome
- Mental/Emotional Problems
- Vision or Hearing Loss
- Urinary Problems
- Thyroid Problems
- Hypoglycemia
- Kidney Disease

### Other Healthcare:

- Current or Recent
- Medical Doctor
- Massage Therapist
- Physiotherapist
- Chiropractor
- Naturopathic Doctor
- Other \_\_\_\_\_

### Medication:

Please list type and condition treated:  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any pin or wire implants , artificial joints or limbs? \_\_\_\_\_

Do you have any other medical conditions you would like us to be aware of? \_\_\_\_\_