Whole Life Center for Health

Massage Client Intake Form

•personal information•

name ____________________ date of birth ____________________

address ____________________

city __________ state __________ zip __________

home phone ____________________ cell phone ____________________

email ____________________

occupation ____________________ employer ____________________

marital status ____________________ spouse's name ____________________

emergency contact/phone number ____________________

physician's name/ phone number ____________________

referred by ____________________

•massage experience•

Have you had a professional massage before? __yes __no

If yes, what types of massage (Swedish, shiatsu, etc.)?

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How long have you been receiving massage therapy?

____

Frequency of massages? ____________________

What are your goals for treatment? ____________________

____

•current health•

Have you recently had an injury, surgery, or areas of inflammation?
__yes __no

If yes, describe____________________

Do you have sensitive skin? __yes __no

Do you have any allergies to oils, lotions, or ointments? __yes
__no

If yes, please explain____________________

List any medications that you are currently taking____________________

____

____

List any known allergies____________________

Do you have any allergies to nuts or peanuts? __yes __no

•health history•

Musculoskeletal
- __Bone or joint disease
- __Tendonitis/Bursitis
- __Arthritis/Gout
- __Jaw Pain (TMJ)
- __Lupus
- __Spinal Problems
- __Migraines/Headaches
- __Osteoporosis

Circulatory
- __Heart Condition
- __Phlebitis/Varicose Veins
- __Blood Clots
- __High/Low Blood Pressure
- __Lymphedema
- __Thrombosis/Embolism

Skin
- __Allergies, specify: ____________________
- __Rashes
- __Cosmetic Surgery
- __Athlete's Foot
- __Herpes/Cold Sores

Digestive
- __Irritable Bowel Syndrome
- __Bladder/Kidney Ailment
- __Colitis
- __Chrohn's Disease
- __Ulcers

Psychological
- __Anxiety/Stress Syndrome
- __Depression

Respiratory
- __Breathing Difficulty/ Asthma
- __Emphysema
- __Allergies,specify: ____________________
- __Sinus Problems

Nervous System
- __Shingles
- __Numbness/Tingling
- __Pinched Nerve
- __Chronic Pain
- __Paralysis
- __Multiple Sclerosis
- __Parkinson's Disease

Reproductive
- __Pregnant, stage____________________
- __Ovarian/Menstrual Problems
- __Prostate

Other
- __Cancer/ Tumors
- __Diabetes
- __Drug/Alcohol/Tobacco Use
- __Contact Lenses
- __Dentures
- __Hearing Aids

Any other medical condition(s) not listed:____________________

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____

Please explain any of the conditions that you have marked above:

____

____

•client agreement•

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all of my medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

____

Signature date

____

name (please print)