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.)?

____

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:____________

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) ____________

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Preferred Contact Information Form

Name: ______________________________ **DOB:** __________________

Preferred Phone Number: (____)____________________

Preferred Method of Appointment Reminders: Calls *or* Texts (circle preference)

E-mail Address for Office Newsletter: ________________@________________.______

____
Patient's Signature

____
Date