Massage Therapy

Intake & Health History Form

BODY COLLECTIVE
BREATHE • MOVE • CONNECT

Date: _____

Name: _____ Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ E-mail: _____

Gender: _____ Preferred Pronoun (he/she/they, etc.): _____

Height: _____ Weight: _____ Age: _____. Referred by: _____

Occupation: _____ Family Physician: _____

Emergency Contact (name & phone): _____

Have you ever received a professional massage before? ☐ Yes ☐ No

If yes, approximate date of last massage? _____

_____

Which best describes the type of massage you're looking for today?

☐ Relaxation ☐ Therapeutic/Corrective ☐ Mix of Both

What kind of pressure do you prefer? _____

Are there any areas you want to avoid being massaged during the session? ☐ Yes ☐ No

_____

Are you pregnant? ☐ Yes ☐ No If yes, how many weeks? _____

Are you currently taking any medications/vitamins/supplements? _____

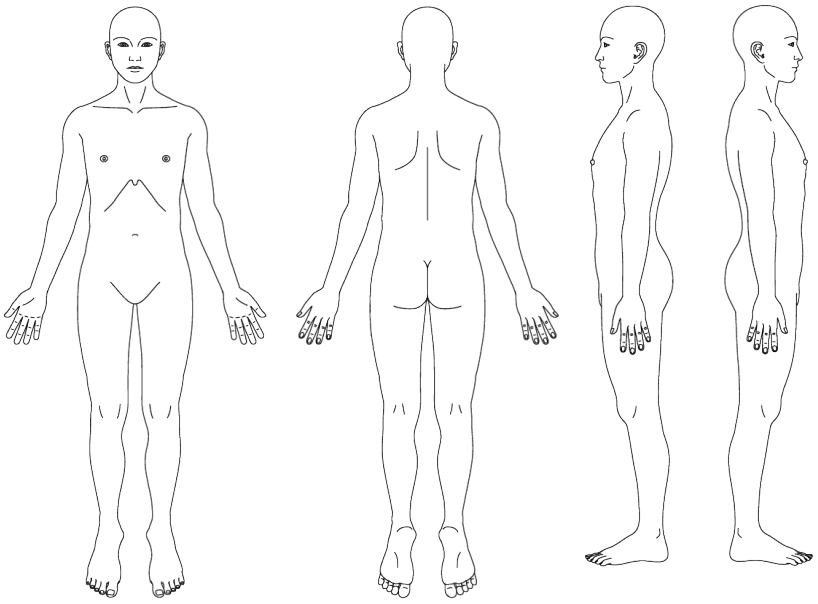
_____

Do you have any of the following? Please circle and explain.

- ☐ Migraines/ Headaches
- ☐ Vision Loss
- ☐ Metal Plates/ Screws
- ☐ Bruising/Wounds
- ☐ Arthritis
- ☐ Recent Surgeries
- ☐ Jaw Pain
- ☐ Current Strains or Injuries
- ☐ Joint Issues
- ☐ Sciatica
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Seizures
- ☐ Diabetes
- ☐ HIV
- ☐ Scoliosis
- ☐ Anxiety
- ☐ Depression
- ☐ Herpes
- ☐ Vertigo
- ☐ Current Cancer
- ☐ Heart Problems
- ☐ Scent/General Allergies
- ☐ Athlete's Foot
- ☐ Plantar Warts
- ☐ Fever
- ☐ Other: _____ _____

Circle the areas where you experience pain, problems, discomfort:

Rate 1-10, 10 being very painful/uncomfortable _____ Date of onset _____



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 medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Proper draping will be used throughout the massage. If at any time I am uncomfortable, I can terminate the session (the Therapist also has this right). I understand that the Therapist does not diagnose illness or disease.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment. I affirm that I have stated all of my known medical conditions and understand that there shall be no Liability on the practitioner's part should I fail to do so.

Client Signature: _____ Date:_____

Therapist Signature: _____ Date:_____