# Client Intake and Medical History Form

Name:_____ DOB:_____
Address:_____
City:_____ State:_____ Zip:_____
Cell Phone: (_____)_____
Email:_____
Occupation:_____

Emergency Contact:_____
Relationship:_____ Phone: (_____)_____

Referred by?/How did you find me?_____

Have you ever received professional massage therapy? Yes or No
If yes, how often do you receive massage?_____

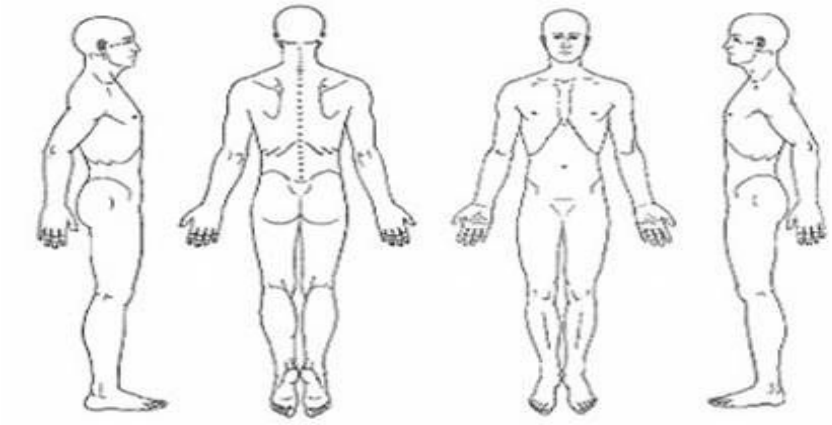
Do you have any allergies/sensitivities to oils or lotions? Yes or No
If yes, please explain:_____

Do you have any difficulty lying on your front, back, or side? Yes or No
If yes, please explain:_____

Do you exercise? Yes or No
If yes, please list the type of activities and frequency:_____
_____

What is the reason for your visit today?_____
_____

What specific area(s) would you like focus on today? Please mark those areas:



Are there any areas you would NOT like work on (such as feet, neck, face, etc.)?_____
_____

Do you have any of theses conditions today? Mark a "Y" for yes those that apply.

___ Sunburn
___ Open cuts
___ Burns
___ Bruises
___ Skin Rash
___ Inflammation
___ Pain
___ Headache
___ Cold or Flu
___ Poison Ivy
___ Fever
___ Pregnant

Please list all medications (prescription and non-prescription) you are currently taking and reason for taking._____

_____

_____

Please list all accidents, injuries, illnesses, and surgeries you have had and when they occurred.

_____

_____

_____

Please review the following conditions and indicate any that you currently have, or have had. Mark "P" for past or "C" for current.

Musculoskeletal:
___ Headaches/migraines
___ Neck pain/whiplash
___ Jaw pain/TMJ
___ Tendonitis
___ Arthritis
___ Osteoporosis
___ Bursitis
___ Carpal Tunnel Syndrome
___ Back pain
___ Scoliosis
___ Disc issues
___ Gout
___ Plantar Fasciitis
___ Strains/sprains
___ Broken/fractured bones
___ Spasms/cramps

Digestive:
___ Irritable Bowel Syndrome
___ Constipation
___ Diarrhea
___ Acid Reflux
___ Bladder problems
___ Kidney problems

Circulatory/Respiratory:
___ Heart conditions
___ Heart attack
___ Stroke
___ High/low blood pressure
___ Varicose veins
___ Blood clots
___ Thrombosis/embolism
___ Lymphedema
___ Allergies
___ Breathing problems
___ Sinus problems
___ Dizziness
___ Fainting
___ Cold feet or hands

Skin:
___ Athlete's Foot
___ Acne
___ Eczema
___ Psoriasis
___ Easy bruising
___ Fungal infections

Nervous System:
___ Fibromyalgia
___ Chronic Fatigue Syndrome
___ Seizures
___ Multiple Sclerosis
___ Muscular Dystrophy
___ Pinched nerve
___ Numbness/tingling
___ Paralysis
___ Parkinson's disease
___ Hypothyroidism

Other:
___ Cancer/active or history?
___ DIabetes
___ HIV/AIDS
___ Hearing impaired
___ Visually impaired
___ Fungal infections
___ Hepatitis
___ Artificial joint/pins/plates
___ Lupus
___ Lyme Disease

Are there any other conditions or diagnoses that you have, or have had, that are not listed above? If so please list._____

# Consent for Massage Therapy and Waiver of Liability

I, _____ (print name) am aware of the benefits and risks of massage therapy and give my consent to receive massage. In addition, I understand and agree to the following:

- Draping will be used during the session and only the area being worked on will be uncovered.
- Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session and informed written consent must be provided.
- Massage therapy is not a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any physical or mental ailment that I am aware of.
- Massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session should be construed as such.
- If I experience any pain or discomfort during the session I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.
- Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, past and present, and have answered all questions accurately and honestly.
- I will keep the therapist updates as to any changes in my medical profile and understand that there shall be no liability on the therapist's' part should I fail to do so.

Signature of Client:_____ Date:_____

Signature of Massage Therapist:_____ Date:_____