

MASSAGE MEDICAL HISTORY & CLIENT INTAKE

Client Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ (Day) _____ (Evening)

Date of birth: _____

Occupation: _____ Employer: _____

Referred by: _____

Health Care Provider: _____ Phone: _____

Emergency Contact Name & Number: _____

Previous experience with massage: _____

Primary reason for appointment/areas of pain and/or tension: _____

Please mark **(X)** for all conditions that apply now. Mark **(P)** for any past conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> headaches, migraines | <input type="checkbox"/> chronic pain | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> vision problems, contact lenses | <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> tension or stress |
| <input type="checkbox"/> hearing problems, deafness | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> depression |
| <input type="checkbox"/> injuries to face or head | <input type="checkbox"/> carpal tunnel | <input type="checkbox"/> sleep difficulties |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> numbness or tingling | <input type="checkbox"/> rashes or athlete's foot |
| <input type="checkbox"/> dental bridges, braces | <input type="checkbox"/> muscle sprains or strains | <input type="checkbox"/> any known infectious disease |
| <input type="checkbox"/> jaw pain, TMJ problems | <input type="checkbox"/> abdominal/digestive problems | <input type="checkbox"/> problems with blood clots |
| <input type="checkbox"/> asthma or lung problems | <input type="checkbox"/> arthritis, tendonitis, bursitis | <input type="checkbox"/> heart or circulatory problems |
| <input type="checkbox"/> allergies or other sensitivities | <input type="checkbox"/> spinal problems or disorders | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> constipation or diarrhea | <input type="checkbox"/> pregnancy | <input type="checkbox"/> high or low blood pressure |
| <input type="checkbox"/> hernia | <input type="checkbox"/> birth control/IUD | <input type="checkbox"/> cancer, tumors or growths |
| <input type="checkbox"/> other medical conditions not listed: _____ | | |

Explain any areas noted above: _____

Current medications, including aspirin, herbs, supplements, etc.: _____

Smoking status: Never Smoked Used to Smoke Currently Smoke*

*Packs per day (amount): _____ *Number of years smoked: _____

If you quit smoking, what year did you quit: _____

Do you currently use cigars, pipes or smokeless tobacco products (i.e., chew, snuff)? NO YES

List all surgeries: _____

List all accidents: _____

List all forms and frequency of stress reduction activities, hobbies, and leisure activities:

List all forms and frequency of physical activity, exercise and sports participation:

The above stated information is true and accurate to the best of your knowledge.

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____