



Massage Therapy Client Health Intake

Name: _____ Date of Birth: _____

Address: _____ City/Zip: _____

Cell: # _____ Home #: _____

Work #: _____ Email: _____

Check here if you would like to receive newsletters and information from Your Body Needs via e-mail.

Referred by? _____

Do you wear contacts? _____ Dentures? _____, hearing aid? _____ Pacemaker? _____

List medications you are currently taking or ceased taking less than 6 months ago?

Are you currently under medical supervision? If yes, explain

Please check any that apply to you. SPECIFY when checked

- | | | | |
|----------------------|--------------------------|------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> |
| Epilepsy or seizures | <input type="checkbox"/> | Allergies | <input type="checkbox"/> |
| Varicose veins | <input type="checkbox"/> | Asthma | <input type="checkbox"/> |
| A contagious disease | <input type="checkbox"/> | Cancer | <input type="checkbox"/> |
| Heart problems | <input type="checkbox"/> | Digestive Conditions | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Breathing Difficulties | <input type="checkbox"/> |
| Sensitive Skin | <input type="checkbox"/> | Sinus Problems | <input type="checkbox"/> |
| Carpel Tunnel | <input type="checkbox"/> | Eating Disorder | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | Pregnant | <input type="checkbox"/> |

Muscular problems (tension, cramping, chronic soreness) _____

Vertebral Conditions (herniated, bulging discs, deviations) _____

Recent accident, injury or surgery _____

Emotional difficulties (depression, anxiety, panic attacks, grieving) _____

Joint problems _____

Arthritis (osteoarthritis, rheumatoid) _____

Circulatory or Blood conditions (arteriosclerosis, varicose veins, phlebitis) _____
Neurological condition (e.g., numbness or tingling in any area of the body, sciatica, damage from stroke, multiple sclerosis) _____
Immune System conditions (chronic fatigue, HIV/AIDS) _____
Skeletal Conditions (osteoporosis, bone cancer, spinal injury) _____
Previous surgery, disease or other medical condition that may be affecting you now _____
Skin condition (e.g., rash, easy bruising, contagious condition) _____
Nut/ Herb/Essential Oil/ Botanical Allergies _____

Any other medical condition your massage practioner should know about?

Do you sit for long hours at a workstation, computer or driving? If yes, describe (how long, how many days per week, etc.)

Do you perform any repetitive movement in your work, sports or hobby? If yes, describe

Do you experience high levels of stress? If yes, do you think stress has affected your health? If yes, indicate how: Muscle tension (), anxiety (), insomnia (), irritability (), other ()

Do you experience difficulty lying on your stomach, back or other part of your body?

Is there an area of your body where you are experiencing tension, stiffness, or discomfort?

Do you have any goals in mind for today's session related to any of the conditions mentioned?

I understand that I should see an appropriated health care provider for diagnosis and treatment of any suspected medical problem. I also understand that is my responsibility to keep my massage practitioner informed of any changes in my health and any medications that I may begin to take in the future. The above information will be treated confidentially.

By signing this form, I also give consent for future sessions. I have read this form and hereby give permission to be administered therapeutic massage.

Signature _____ Date _____