# Health History Intake Form

1. Name: _____
2. Address: _____ City: _____State & Zip: _____
3. Home Phone: _____ Work Phone: _____
4. Email _____Occupation:_____
5. Age: _____ Date of Birth: _____ Referred by? _____
6. Do you prefer light, medium or deep pressure? _____
7. Are you pregnant? _____ When was your last massage? _____

Have you had surgery, serious injury, severe illness or accidents in the last 2 years? ____ Please explain: _____
_____

Medication: Reason for your medication:

_____ _____
_____ _____

Please check if you have a present condition or history of the following:

| | | |
|---|---|---|
| _ Asthma | _ Varicose Veins | _ Numbness or Tingling |
| _ Headaches | _ Herniated Disc | _ High Blood Pressure |
| _ Neck Pain | _ Fibro-Myalgia | _ Low Blood Pressure |
| _ Bursitis | _ Low Back Pain | _ Skin Disorder _____ |
| _ Scoliosis | _ Osteoperosis | _ Kidney Disease |
| _ Blood Clots | _ Heart Condition | _ Nerve Condition |
| _ Thrombosis | _ Cancer | _ Diabetes |
| _ Arthritis | _ Dizziness | _ Limited range of motion |
| _ Fractures | _ Plantar Warts | _____ |

Comments:_____
Do you have any medical conditions that I should be aware of before giving you a massage? _____
Do you have areas of tension? _____
Do you have areas of pain? _____

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment, of pharmaceuticals, nor do they perform spinal manipulations.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension of spasm, and increasing circulation and energy flow.

I understand that any form of sexual advances will not be tolerated and I will be required to pay for the full amount of time allotted for my appointment and be asked to leave the premises.

Signed:_____ Date:_____