IMPORTANT: Your data cannot be saved, please complete form and print it.

Massage Therapy Client Health Intake Form

Amanda Donis Therapeutic Massage

Patient Information

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

E-mail: _____

Occupation: _____ Date of Birth: _____

Emergency Contact Person: _____ Phone: _____

Are you currently under a physicians care for an acute or chronic illness? Y ☐ N ☐

If yes please explain: _____

If yes, who is your health care provider: _____

Are you currently taking any prescribed medication or dietary supplements? Y ☐ N ☐

If yes please explain: _____

Have you received a massage before? Y ☐ N ☐ If yes, when: _____

How did you hear about me? _____

What are your goals for this session: _____

Please list areas of tension, stress and/or pain you wish to be addressed: _____

_____

Health Information

Please mark an (X) by all current conditions and (P) for all past conditions

- ☐ Abdominal /digestive problems
- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis/tendonitis
- ☐ Asthma or lung cond.
- ☐ Athletes foot
- ☐ Blood clots
- ☐ Chronic pain
- ☐ Circulatory/heart problems
- ☐ Constipation/diarrhea
- ☐ Depression
- ☐ Diabetes
- ☐ Fatigue
- ☐ Headaches, migraine
- ☐ Hearing problems
- ☐ Hernia
- ☐ High blood pressure
- ☐ Jaw pain/TMJ pain
- ☐ Low blood pressure
- ☐ Muscle/bone injuries
- ☐ Muscle/joint pain
- ☐ Numbness/tingling
- ☐ Pregnancy
- ☐ Rash/fungus
- ☐ Sinus problems
- ☐ Sleep difficulties
- ☐ Spinal disorders
- ☐ Sprain/strain
- ☐ Tension/stress
- ☐ Vision problems
- ☐ Varicose veins
- ☐ Other _____

Elaborate on noted areas above: _____

_____

Please list any recent injuries or surgeries within the past 5 years: _____

_____

Please list your stress-reduction activities, hobbies, exercise and/or sport participation: _____

_____

Please list areas of tension, stress and/or pain you wish to be addressed. Use a number from 1-10 to indicate the intensity or pain level or the problem area (1=least painful, 10=most, worst).

_____