Client Health History Intake

date of initial visit _____

referred by _____

Please take a moment to share some information about yourself with us. This will help us to customize your treatment to better fit your needs and goals and keep in mind any techniques that may be medically unsuitable for you.

name _____date of birth _____male_____female_____

street address _____city _____ state _____ zip _____

best phone number to be reached at_____ alternate phone number_____

occupation_____chiropractor_____

physician_____emergency contact name and phone _____

What are you primary health concerns? List as many as you can, in the order of their importance to you.

_____

_____

_____

Have you received a professional massage? What did you like or dislike about the massage? _____

_____

List any accidents, surgeries, or injuries in the past 5 years_____

_____

How would you rate you level of physical activity? None Light Moderate Heavy

Do you participate in any sports or hobbies? _____

_____

Do you have any complaints or diagnoses in the following areas, underline if you have experienced it in the past 6 months:

Yes No

- ❍ ❍ **Musculoskeletal:** artificial joints / bursitis / fibromyalgia / arthritis / whiplash / plantar fascitis / joint pain / stiffness / broken bones / spasms, cramps / weakness / sciatica
- ❍ ❍ **Lymph/Immune System:** allergic reactions / HIV/AIDS / slow wound healing
- ❍ ❍ **Skin:** athlete's foot / burns / cold sores / warts / rashes / acne, boils / color changes / lumps / eczema / hives / itching
- ❍ ❍ **Miscellaneous Conditions:** cancer / diabetes / heat or cold intolerance / allergies
- ❍ ❍ **Mental/Emotional:** depression / anxiety / tension, stress
- ❍ ❍ **Head:** headaches / migraines / head injury / jaw pain
- ❍ ❍ **Neurological:** vertigo / dizziness / tingling / multiple sclerosis / Parkinson's / seizures
- ❍ ❍ **Eyes:** cataracts / glaucoma
- ❍ ❍ **Cardiovascular:** heart disease / low blood pressure / blood clots / easily bruise, bleed / deep leg pain / varicose veins / high blood pressure / deep vein thrombosis / stroke

❍ ❍ **Female Reproductive** (applies to lifetime): painful menses / PMS

Age of first menses (period) _____ Age of last menses _____

How many days do you menstruate for? _____

Are you currently taking birth control? _____

Pregnancies_____Births_____

Complications_____

Family History: Do you have a family history of any of the following diseases or conditions?
Please include your parents, brothers/sisters, and grandparents, if known. Circle all that apply.

Anemia	Cancer	Heart Disease	Mental Illness	Alzheimer's	Arthritis	Diabetes
Hypertension	Stroke	Asthma	Epilepsy	Kidney Disease	Parkinson's	Multiple Sclerosis

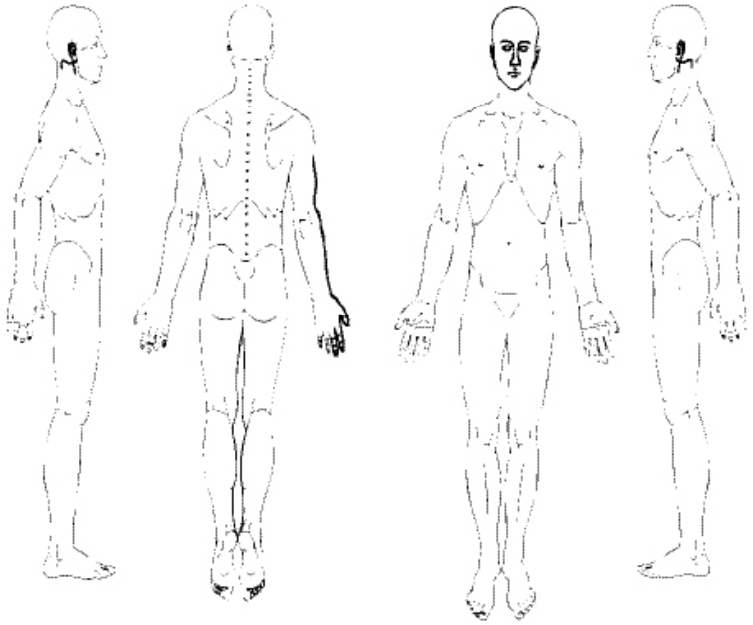
Please list other significant family medical history not listed _____

_____

Please mark on the body below any areas where you experience tension, stiffness or other discomfort and describe the sensation_____

_____

_____



_____ (initial) I understand the massage therapy given here is for general wellness purposes, including stress reduction, relief from muscular tension or spasm, the promotion of circulation, lymph activity and flexibility. I understand a massage therapist will never touch genitals, breast tissue or any other area I instruct them not to touch. I understand massage therapists do not diagnose illness, disease, or any other physical or mental problem. I also understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I further understand that it is my responsibility to inform the massage therapist of any existing medical conditions I may have, and keep the massage therapist informed of any changes in my health and medications in the future. I understand that potential risks of massage include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface bruising. I understand I have the right to refuse massage therapy treatment at any time during the session.

_____ _____

client signature date

_____ _____

email