THE CENTER
HOLISTIC HEALTH CENTER
Healing for Body • Mind • Spirit

MASSAGE THERAPY INTAKE & HEALTH HISTORY

Please complete this page as accurately as possible so your therapist can provide safe, personalized care.

CLIENT INFORMATION

Name _____ Date _____

Occupation _____

CURRENT CONCERNS & HEALTH CARE

Specific pain you wish to have treated - please describe:

Activities that are difficult or painful to do:

Currently under the care of a health practitioner? ☐ Yes ☐ No If yes, who/why? _____

Current medications, including skin patches: _____

Recent trauma or injuries: _____

Surgeries and dates: _____

Prostheses, pins, bars, implants, etc.: _____

LIFESTYLE & TREATMENT GOALS

Frequent activities:	☐ Sitting	☐ Standing	☐ Lifting	☐ Other
Healthy diet:	☐ Always	☐ Frequently	☐ Sometimes	☐ Rarely
Adequate sleep:	☐ Every Night	☐ Most Nights	☐ Difficulty	☐ Sleep Aid
Sleep position:	☐ Back	☐ Side	☐ Stomach	☐ Restless
Habits:	☐ Coffee/Tea	☐ Sugar/Sodas	☐ Tobacco	☐ Alcohol
Stress felt in:	☐ Head/Neck	☐ Shoulders	☐ Back	☐ Digestive/Ext.

Water per day: _____ Relaxation practice: _____

Professional massage before? _____ Goals for treatment: _____

Pregnant/trying to become pregnant? ☐ Yes ☐ No Allergic to nut oils? ☐ Yes ☐ No

HEALTH CONDITIONS

Please check any illness or medical condition you have or have had:

☐ Allergies	☐ Arthritis	☐ Asthma	☐ Blood clots	☐ Bruise easily
☐ Cancer	☐ Carpal tunnel	☐ Chest pain	☐ Chronic cough	☐ Constipation
☐ Depression	☐ Diabetes	☐ Disc problems	☐ Edema	☐ Epilepsy
☐ Fatigue	☐ Fractures	☐ Headaches	☐ Heart condition	☐ High blood pressure
☐ Infectious condition	☐ Kidney condition	☐ Limited movement	☐ Liver condition	☐ Low blood pressure
☐ Neck pain	☐ Numbness	☐ Osteoporosis	☐ Phlebitis	☐ Pinched nerves
☐ Pins and needles	☐ Poor circulation	☐ Sciatica	☐ Scoliosis	☐ Sinus problems
☐ Sleep Apnea	☐ Skin disorders	☐ Stroke	☐ Swollen joints	☐ Varicose veins

Other condition(s) therapist should know about: _____

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CLIENT CONTACT INFORMATION & CONSENT

CONTACT INFORMATION

Name _____ Date _____ Phone _____

Address (City, State & Zip) _____

E-mail _____ Referred by _____

Age _____ Date of Birth _____ Occupation _____

Emergency Contact (Name/Phone) _____

How did you hear about The Center? _____

CONSENT FOR MASSAGE THERAPY

- The unclothed body will be properly draped at all times for your warmth, sense of security, and as a mark of massage professionalism.
- Focused attention and manual therapy will be given as agreed upon by therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and health promotion. My therapist has discussed the potential benefits and possible side effects of this therapy. I have been given the opportunity to ask questions.
- I as client agree to provide complete and accurate health information and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is not intended to be a substitute for primary medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist.
- Written referral is requested from your primary care provider if: 1) you are currently receiving care, or 2) you have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strokes may be adjusted to my level of comfort.
- I understand that this professional massage is therapeutic in nature and is performed by a trained, state-licensed therapist.
- I understand that the massage is not sexually oriented in any way and that any illicit or suggestive remarks or behavior on my part will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.
- I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent.
- I have read this form and hereby freely give my permission to receive massage therapy.

Client Name (print) _____

Client Signature _____ Date _____