

## **Preferred Massage - Client Health History Intake**

Please take a moment to answer the following questions. The information you provide will be used to customize your session to your needs and exclude any techniques that may be medically unsuitable for you.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone Numbers: (Home/Cell) \_\_\_\_\_ (Work) \_\_\_\_\_ Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Physician \_\_\_\_\_ Chiropractor \_\_\_\_\_ Referred By: \_\_\_\_\_

Emergency Contact & Phone: \_\_\_\_\_

Current Medications/OTC/Supplements & WHY: \_\_\_\_\_

---

**Please answer the following to the best of your knowledge.**

1. Have you had a professional massage before?  Yes  No
2. Do you have allergic reactions to oils, lotions, or other substances put on your skin, or to any nuts?  Yes  No
3. Do you have any particular goals for this massage session? \_\_\_\_\_
4. If you are currently under medical supervision, please explain \_\_\_\_\_
5. Please check any condition/symptom listed below that applies to you:

**Musculoskeletal System**

- Artificial Joint
- Baker's Cyst
- Bursitis
- Fibromyalgia or CFS
- Muscular Dystrophy
- Osteoarthritis
- Osteoporosis
- Plantar Fasciitis
- Rheumatoid Arthritis
- Tendonitis
- Whiplash
- Other \_\_\_\_\_

**Nervous System**

- Alzheimer's
- Herpes Zoster/Shingles
- Multiple Sclerosis
- Parkinson's Disease
- Peripheral Neuropathy
- Seizures
- Spinal Cord Injury
- Numbness
- Other \_\_\_\_\_

**Circulatory System**

- Atherosclerosis
- Deep Vein Thrombosis (DVT)
- Heart Attack
- High Blood Pressure
- Leukemia
- Low Blood Pressure
- Stroke
- Varicose Veins
- Other \_\_\_\_\_

**Digestive System**

- Crohns
- IBS
- Ulcers
- Ulcerative Colitis
- Other \_\_\_\_\_

**Lymph/Immune System**

- Allergic Reactions
- Chronic Fatigue
- HIV/AIDS
- Lupus
- Lymphoma
- Other \_\_\_\_\_

**Respiratory System**

- Asthma
- Chronic Bronchitis
- Sinusitis
- Other \_\_\_\_\_

**Integumentary System (Skin)**

- Athlete's Foot
- Boils
- Burns
- Cold Sore/Herpes
- Dermatitis
- Impetigo
- Open Sores/Wounds
- Psoriasis
- Rashes
- Warts
- Other \_\_\_\_\_

**Miscellaneous Conditions**

- Cancer
- Depression
- Diabetes
- Easy Bruising
- Headaches
- Migraines
- Numbness
- Pregnant
- Other \_\_\_\_\_

6. Please list any accidents or operations you have had and dates: \_\_\_\_\_

---

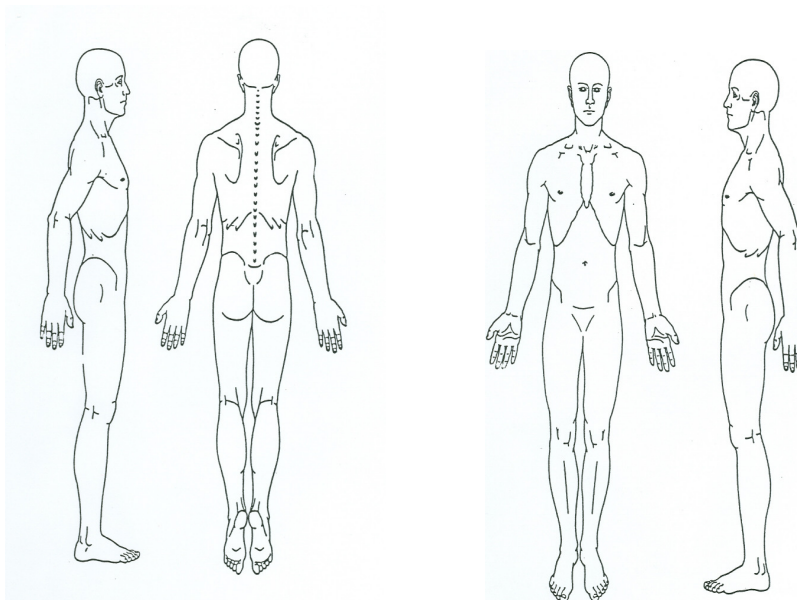
7. Please list any Sports/Regular Physical Activities **you do**:

- |           |            |              |              |
|-----------|------------|--------------|--------------|
| Cards     | Running    | Tennis       | Quilting     |
| Gardening | Volleyball | Walking      | Swimming     |
| Golf      | Bowling    | Lift Weights | Other: _____ |

8. Please circle the level of physical activity you do:

None                      Light                      Moderate                      Heavy

9. Please mark on the body forms with an "X" where you are experiencing any tension, stiffness or other discomfort. Please describe the sensation (burning, stinging, aching, pins-n-needles, etc.): \_\_\_\_\_



\_\_\_\_\_ (initials) 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 areas I instruct them not to touch. I understand massage therapists do not diagnose illness, disease, or any other physical or mental disorder, do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. I also 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 level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session. Consent for Treatment: I authorize the performance of massage therapy techniques and procedures and understand that I will receive them from a Certified Massage Therapist at CEC Consultants, Inc. dba Preferred Massage. I understand that payment is expected at the time of service.

\_\_\_\_\_ (initials) My appointment time has been reserved for me. In the event that I may have to cancel an appointment, I will kindly give a 24-hour notice to the facility. I understand that if a 24-hour notice is not given, I may be charged for the scheduled appointment. If I arrive late to my appointment, I understand that my massage will conclude at my scheduled time to respect the practitioner's client schedule.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I understand that I may be refused treatment if I appear obviously intoxicated or under the influence of drugs.**

Signature \_\_\_\_\_ Date \_\_\_\_\_