

# A Calmness Within Massage Therapy

## Client Health Intake Form

Please fill out completely and sign.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

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

Daytime phone \_\_\_\_\_ Evening phone \_\_\_\_\_

Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Occupation \_\_\_\_\_ Birth date \_\_\_\_\_

How did you hear about us?    PMTI    Gazette    Website    Mailer    Discovery Channel  
Friend \_\_\_\_\_ Other \_\_\_\_\_

Have you had a professional massage before?     Yes     No

### Current Health

Where are you currently feeling pain or tension? \_\_\_\_\_

Do you have limited range of motion? Where? \_\_\_\_\_

What exercise do you regularly perform? \_\_\_\_\_

Do you have allergies or sensitivity to     oils     lotions     scents \_\_\_\_\_

Are you pregnant?     No     Yes, what week? \_\_\_\_\_

### Medical History

Are you currently under a doctor or therapist's care?     Yes     No

If yes, for what? \_\_\_\_\_

Please describe any injuries or surgeries in the past 5 years \_\_\_\_\_

Please check any of the following conditions you have now or have had in the past

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergies                               | <input type="checkbox"/> Headaches                                       | <input type="checkbox"/> Rheumatoid arthritis                |
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Heart disease/attack                            | <input type="checkbox"/> Sciatica                            |
| <input type="checkbox"/> Blood clots                             | <input type="checkbox"/> High/low blood pressure                         | <input type="checkbox"/> Skin disorders                      |
| <input type="checkbox"/> Broken/fractured bones                  | <input type="checkbox"/> Jaw pain (TMJ)                                  | <input type="checkbox"/> Slipped/degenerative/<br>fused disc |
| <input type="checkbox"/> Cancer<br>specify primary site<br>_____ | <input type="checkbox"/> Lymph node removal<br>specify location<br>_____ | <input type="checkbox"/> Tendon/ligament/<br>cartilage tear  |
| <input type="checkbox"/> Diabetes                                | <input type="checkbox"/> Numbness  | <input type="checkbox"/> Varicose veins                      |
| <input type="checkbox"/> Edema (swelling)                        | <input type="checkbox"/> Osteoarthritis                                  | <input type="checkbox"/> Other, please specify<br>_____      |
| <input type="checkbox"/> Fibromyalgia                            | <input type="checkbox"/> Osteoporosis/osteopenia                         | _____  |

Are you taking any of the following types of medication?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Blood pressure meds | <input type="checkbox"/> Pain killers        | <input type="checkbox"/> Anti-inflammatories |
| <input type="checkbox"/> Blood thinner       | <input type="checkbox"/> Cortisone injection | <input type="checkbox"/> Muscle relaxants    |

