Healthworks
NUTRITION CENTRE

MASSAGE INTAKE FORM

Name:____Date: ____________________

Address: _________________________________ City:__________________ Province:_____ Postal Code:______

Cell Phone: ___________________________Other Phone:_______________________ D.O.B: mo / day / year

Email: _______________________________________ Occupation: ______________________ Hours/week:_____

Emergency Contact: ____ Phone# ____________________________

Referred by ____

Have you had a professional massage before? **YES/NO** If yes, how often: __________________________________

Do you have any difficulty lying on your front, back or side? **YES/NO**

Explain: ____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? **YES/NO**

Explain: ____

Do you have sensitive skin? **YES/NO** What type of pressure do you prefer? Light / medium / deep

Are you wearing contact lenses / dentures / hearing aid / prosthetics? Please circle.

Do you sit for long hours at a workstation, computer, or driving? **YES/NO**

Describe: ____

Do you perform any repetitive movement in your work, sports, or hobbies? **YES/NO**

Describe: ____

How do you feel the stress in your work, family, or other aspect of your life affected your health? **YES/NO**

Describe: ____

Circle any specific areas you would like the massage therapist to concentrate on during the session:

Is there a specific area of the body that you are experiencing tension, stiffness, pain or discomfort?

YES/NO

Describe: ______________________________

____

____

Do you have any particular goals in mind for this massage session? **YES/NO**

Explain: _______________________________

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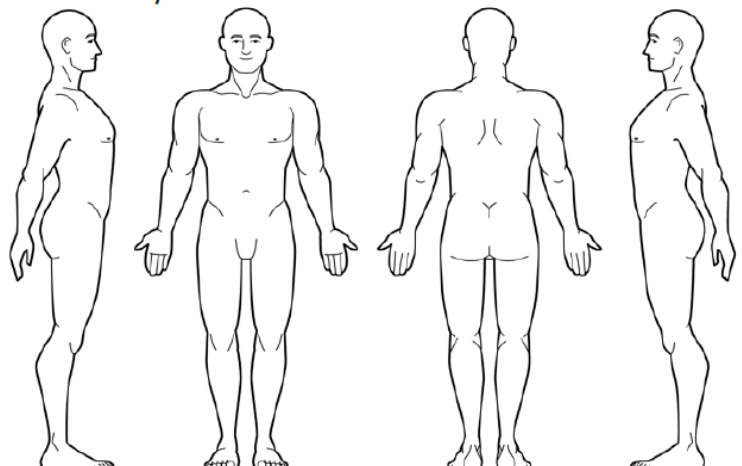

Medical Information

Do you currently or have you ever had any of the following:

Allergies/sensitivity
Atherosclerosis
Artificial joint
Back/neck problems
Cancer
Carpal tunnel syndrome
Circulatory disorder
Contagious skin condition
Current fever
Decreased sensation
Deep vein thrombosis/blood clots
Diabetes
Easy bruising
Epilepsy
Fibromyalgia
Headaches
Heart condition
High or low blood pressure
Joint disorder
Migraines
Open sores or wounds
Osteoarthritis
Osteoporosis
Phlebitis
Pregnancy (__months)
Recent fracture
Recent accident or injury
Recent surgery
Rheumatoid arthritis
Sprains/strains
Swollen glands
Tendonitis
Tennis elbow
TMJ
Varicose veins

Are you currently under medical supervision? **YES/NO**

Explain:____

Do you see a chiropractor? **YES/NO** How often?___________

Are you taking any medications? **YES/NO**

Explain: ____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? ____

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I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature____ Date ____________________________

Therapist Signature____ Date____________________________