



Adult Confidential Intake & Health History form

Personal Information

Today's Date: _____

Name: _____ Sex: Male Female
Last First M.I.

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone Numbers: _____
Home Work Mobile

E-Mail: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you? _____

Is this your FIRST professional massage? ____ If no, how frequently do you get a massage? _____

Goals for session

What do you hope to accomplish from today's massage? _____

Are you aware of any tension holding spots in your body? ____ If yes, location(s): _____

Are you Pregnant? __Yes __No If yes, how far along? _____

Medical History

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accidents or injuries? _____

Do you feel that you have recovered from these events? ____ Please explain: _____

Do you have any chronic, ongoing pain that you deal with on regular basis? ____ Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Are you receiving any other type of medical treatment? ____ Please explain: _____

Please list any medication (vitamins, herbs, or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____

Are you currently under the care of a physician? ____ Whom? _____

Please list reason(s): _____

Are there any other health concerns you wish to discuss today? ____ If yes, please describe _____

Do you inform your doctor that you have or/are receiving massage therapy? _____



Client's Name: _____
Last First M.I.

Are you currently experiencing any of the following conditions? (yes/no)

___ Flu or Cold ___ Inflammation ___ Fever ___ Infection ___ Contagious Disease ___ TB

Please check (✓) any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

- | | | | |
|--------------------------|----------------------------|--------------------------|-----------------------------|
| MUSCULOSKELETAL | CIRCULATORY | NERVOUS SYSTEM | RESPIRATORY |
| ___ Fibromyalgia | ___ Anemia | ___ ALS | ___ Pneumonia |
| ___ Spasms/Cramps | ___ Hemophilia | ___ Multiple Sclerosis | ___ Sinusitis |
| ___ Sprains/Strains | ___ Hypertension | ___ Parkinson's disease | ___ Asthma |
| ___ Osteoporosis | ___ Low blood pressure | ___ Bell's Palsy | ___ Trouble breathing |
| ___ Postural deviations | ___ Reynaud's Disease | ___ Neuritis | ___ Dizziness |
| ___ Gout | ___ Varicose veins | ___ Spinal cord injury | ___ Other |
| ___ Osteoarthritis | ___ Heart condition | ___ Stroke | |
| ___ Rheumatoid arthritis | ___ Blood clots/Phlebitis | ___ Trigeminal Neuralgia | OTHER |
| ___ TMJ dysfunction | ___ Diabetes | ___ Seizure disorders | ___ Insomnia |
| ___ Cysts | ___ Other | ___ Numbness | ___ Sleep Apnea |
| ___ Bursitis | | ___ Tingling/Twitching | ___ Anxiety/Panic Attacks |
| ___ Plantar fasciitis | SKIN | ___ Other | ___ PMS |
| ___ Tendonitis | ___ Fungal Infections-Acne | | ___ Physical Abuse |
| ___ Torticollis | ___ Impetigo | DIGESTIVE | ___ Emotional Abuse |
| ___ Whiplash syndrome | ___ Dermatitis/Eczema | ___ Ulcers | ___ Grief Process |
| ___ Carpal tunnel | ___ Psoriasis | ___ Irritable bowel | ___ Cancer |
| ___ Sciatica | ___ Open wound or sore | ___ Colitis | ___ Substance abuse |
| ___ Thoracic outlet | ___ Rashes | ___ Gallstones | ___ Pregnancy |
| ___ Headache | ___ Warts/Moles | ___ Hepatitis | ___ Chronic Fatigue |
| ___ Leg pain | ___ Athletes foot | ___ Crohn's disease | ___ HIV/AIDS |
| ___ Arm pain | ___ Other | ___ Diarrhea | ___ Lupus |
| ___ Shoulder pain | | ___ Gas/Bloating | ___ Kidney Disease |
| ___ Low back pain | | ___ Indigestion | ___ Bladder Infection |
| ___ Mid back pain | | ___ Other | ___ Postoperative situation |
| ___ Hip pain | | | ___ Edema |
| ___ Other | | | ___ Other |

Techniques to be used may include Swedish, Deep Tissue, Trigger Point, Reflexology, Joint range of motion Techniques and stretches, Energy work, Lymphatic drainage, Shiatsu, and Cranial Sacral.

Therapeutic bodywork and massage therapy is not intended to replace the services of a physician, physical therapist, chiropractor, or other licensed medical provider, nor does it constitute a doctor-patient relationship. The terms "therapy" and "therapeutic" do not include diagnosis, the treatment of illness or disease, or any service or procedure for which a license to practice medicine, chiropractic, physical therapy, or podiatry is required.



Client's Name: _____
Last First M.I.

Massage Therapy Informed Consent

I understand that (Please read and initial):

- _____ Massage therapy or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment of an illness. I take responsibility for consulting with my physician for any ailment or condition of concern to me.
- _____ Massage therapy/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such.
- _____ I understand that my feedback is an essential element in my treatment. I have the right to terminate the session at any time, regardless of the reason.
- _____ Therapeutic bodywork and massage includes treatment to face, neck, shoulders, back, arms, buttocks, hip flexors, legs (front and back), pectorals, abdominals, ribs, hands and feet.
- _____ In a professional relationship, sexual intimacy between therapist and client is never appropriate, and should be reported to the Texas Department of State Health Services (www.dshs.state.tx.us) and any other complaints deemed necessary.
- _____ Massage to the breasts of females will not be engaged unless a written consent is signed. Genital massage is NEVER Performed.
- _____ I understand draping is to be used, preferred method is to be covered at all times, meaning only the body part being massaged will be exposed, no exceptions. In some cases, such as stretching and movement exercises, you will be asked to wear workout clothes or a swimsuit. Your modesty will be honored at all times.
- _____ I acknowledge that if I am unable to keep a scheduled appointment, **24 hours notice is required** (medical emergencies excluded) or I may be charged for the time reserved.

*I have read and understood this Client Intake and Health History form in its entirety. If at any time there are changes in the information given, or in my condition, I will notify the therapist and update this form before receiving additional massage. I have stated all my known medical conditions and have answered all questions honestly. I understand that any information exchanged during a massage/bodywork session is confidential and is only used to provide you with the best health care services

*The massage/bodywork treatment I am requesting is for the purpose(s) of relaxation, stress reduction, relief from muscle tension or spasm, to improve range of motion, circulation or energy, and to receive a positive experience of touch. If I experience any pain or discomfort during the massage session, I will immediately communicate that to the therapist so that treatment can be adjusted accordingly.

*I hereby agree and abide by the regulations applicable to a making a massage appointment. I forever expressively release, indemnify, and hold harmless Good Shepherd Medical Center, Healthy Living Institute and Spa, and their respective agents, servants and employees for any and all liability whatsoever. I have reviewed this form, and the information contained in my Client Intake and Health History, with the massage therapist. By my signature, I consent to receive massage therapy.

Client's Signature Today's Date

Therapist's Signature Today's Date