JENNY'S TOUCH THERAPEUTIC MASSAGE THERAPY

HEALTH HISTORY INTAKE FORM

(Please Print)

Today's date:

CLIENT INFORMATION

Client name:		Birth date: / /
Street address:	City:	State/ ZIP Code:
Email:	Home phone no.: ( )	Cell phone no.: ( )
Emergency Contact	Phone no.: ( )	Referred by:
Occupation:	PCP:	PCP phone no.: ( )

Permission to consult with PCP? (please check one box) : ❑ Yes ❑ No

Have you ever received Professional massage/bodywork before? ❑ Yes ❑ No How Recently? _____

What kind of pressure do you prefer?	Light ❑ Medium ❑ Firm ❑	Pain Scale: Poor 1 2 3 4 5 6 7 8 9 10 Excellent
		How do you feel Today? _____

What are your goals/expected outcomes for receiving massage therapy? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc): _____

_____

❑Muscle/joint pain or stiffness ❑Arthritis ❑Osteoporosis ❑High/Low Blood pressure ❑Memory loss, confusion, easily overwhelmed ❑Shortness of breath/asthma ❑Diabetes ❑Varicose veins ❑Endocrine/thyroid conditions ❑Blood Clots ❑Bruise easily	❑Headaches/Migraines ❑Stroke, heart attack, CHF ❑Dizziness, ringing in the ears ❑Numbness or tingling ❑Digestive conditions ❑ General swelling/Pitting edema ❑Depression, anxiety ❑ Sensitive to touch/pressure ❑Cancer ❑Scoliosis ❑Broken bones ❑Herpes	❑Epilepsy/Seizures ❑Neurological (MS, Parkinson's, chronic pain) ❑Degenerative spine disk ❑Kidney disease, infection ❑Infectious/Contagious disease: _____ ❑ Other: _____

Comments:

_____

_____

_____

List of Current Medications/Supplements: _____

Allergies? ❑ Yes ❑ No Please List:_____	Please List areas of your body you DO NOT wish to receive treatment:_____

Pre-Natal risk assessment addendum			
Are you pregnant? ❑ Yes ❑ No (please fill out below if you answered yes)			
How many weeks? _____	OB/GYN/Mid-Wife name: _____	Phone no.:	( )

How active is Baby? _____ When is baby most active? _____

Nausea/Vomiting?	❑ Yes ❑ No	If yes, please explain: _____
Diarrhea/Indigestion?	❑ Yes ❑ No	If yes, please explain: _____
Bleeding/Spotting?	❑ Yes ❑ No	If yes, please explain: _____
Swelling?	❑ Yes ❑ No	If yes, please explain: _____
Contractions?	❑ Yes ❑ No	How often: _____

- By signing below I agree that my OB/GYN/Mid-wife has given me permission to receive massage therapy and I am not classified as a high risk pregnancy patient>

Client Signature: _____ Date: _____

Massage Therapist Signature: _____ Date: _____

Consent for Treatment

By signing below I acknowledge I have answered everything honest and to the best of my ability, and If I experience any pain or discomfort during my session, I will immediately inform the Massage Therapist so that the pressure and/or technique may be adjusted to my level of comfort. I further understand that massage therapy should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness and that nothing said in the course of the session/treatment given should be construed as such. Massage therapy should not be performed under certain medical conditions without written consent form a medical professional; I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the Massage Therapist updated as to any changes in my medical profile and understand that there shall be no liability on the Massage Therapist's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me, the client, will result in immediate termination of the session/treatment and I, the client, will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

_____ _____
Client/Guardian signature Date

_____ _____
Massage Therapist Date

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