Amy Johnson, Licensed & Certified Massage Therapist

10136 Kings Bench Ct., Ellicott City, MD 21042 410-967-0389

HEALTH INTAKE FORM

Client information will always be held in the strictest confidence, according to law.

Client Name_____ **Today's Date**_____

Address_____

Telephone (Day)_____ **Telephone (Evening)**_____

Cellphone _____ **Email** _____

Occupation_____ **Birth Date**_____ **Referred by**_____

1. **What are you hoping to gain from massage?**_____
2. **Have you ever had a professional massage or other type of bodywork?**_____ **If so, what kind(s)?**_____
3. **Are you presently under a doctor's or therapist's care?**_____ **If so, for what?**_____

_____

4. **Please list current symptoms:**_____
5. **Please list any medications you are taking:**_____

   What side effects, if any, do you experience?_____
6. **Do you smoke?**_____
7. **Do you have any allergies?**_____ **If so, to what?**_____
8. **Do you wear contact lenses?**_____
9. **Are you pregnant?**_____ **If so, what is your due date?**_____
10. **What kind of exercise do you do regularly?**_____

    How often?_____

11. Please circle any of the following conditions *which you currently have or have experienced in the past,* indicating the approx. dates in the spaces to the right. Some may be contraindications for massage. Massage is not designed to treat the following conditions but this information will help me to plan the session.

Systemic Infections: **mononucleosis**_____ **hepatitis**_____ **HIV**_____
Fever blister(s)_____ **Genital herpes**____ **other virus**_____

Cardiovascular: **varicose veins**_____ **phlebitis**_____ **stroke**_____ **blood clots**____
acute inflammation_____ **heart attack**_____ **heart disease**_____
high blood pressure_____ **low blood pressure** _____
other_____

Musculoskeletal: **whiplash_____ low back pain_____ strain/sprain____fracture____ osteoporosis_____ scoliosis_____ arthritis_____ foot pain___ torn ligaments/cartilage/tendons_____ sports injuries_____ other_____**

Neurological: **sciatica_____ headaches_____ numbness/weakness/coldness in limbs_____slipped disc____ other_____**

Skin Infections: **eczema_____ burns_____ other_____**

Endocrine: **diabetes_____ hypoglycemia_____ other_____**

Respiratory: **emphysema_____ hay fever_____ asthma_____ other_____**

Reproductive: **prostatitis_____ other_____**

Digestive: **constipation_____ diarrhea_____ colitis_____ Crohn's _____ other_____**

Urinary: **UTIs_____ frequent urination_____ other_____**

Psychiatric: **mood swings_____ sleep disorders_____ exhaustion_____ depression_____acute anxiety____ other _____**

Cancer: **Are you currently being treated for cancer, or have you ever been? Please describe w/ dates:_____**

Surgery: **Please describe w/ dates:_____**

Miscellaneous: **Please describe any other conditions (include dates)_____**

_____

_____

Is there anything else you would like to share with me at this time? If so, feel free to write it here

_____

_____

I am consenting to massage (for myself or my minor child) and have provided complete and accurate information to this massage provider and agree to provide updated information to keep this record up to date with any health/medical changes. I have also read and agree to the Policy Statement provided me.

_____

SIGNATURE OF CLIENT (OR ADULT GUARDIAN IF CLIENT IS UNDER 18) Date_____