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 Cell_____ **Telephone Home** _____

Email _____

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

***Emergency Contact Name**_____ **Cell phone**_____

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/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?**_____ **Do you wear contact lenses?** _____
7. **Do you have any allergies?**_____ **If so, to what?**_____
8. **Do perform any repetitive movement in your work, sports or hobby?**_____
9. **Are you pregnant?**_____ **If so, what is your due date?**_____
10. **Do you sit for long hours at a workstation, computer or driving?** _____
11. **What kind of exercise do you do regularly/how often?**_____
12. **Have you recently had an injury, surgery or areas of inflammation?** _____

12. 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 your session*****.**

Systemic Infections: **mononucleosis**_____ **hepatitis**_____ **HIV**_____
Fever blister(s)_____ **Genital herpes**_____
COVID-19 or other virus, specify_____

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: **_____**

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 *understand that because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and am consenting to massage (for myself or my minor child). I 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 acknowledge that massage therapy is not a substitute for medical care, examination or diagnosis. I have also read and agree to the Policy Statement provided me.*

Signature of Client (or adult guardian if client is under 18) **Date _____**