Johnston Community College Therapeutic Massage Clinic

Health Intake Form

Personal Information

Name ____ Date of Initial Visit _______________________

Phone (Cell) (_____)________________ Phone (Home) (_____)________________

Address __________________________________City ____________ State __________ Zip ________

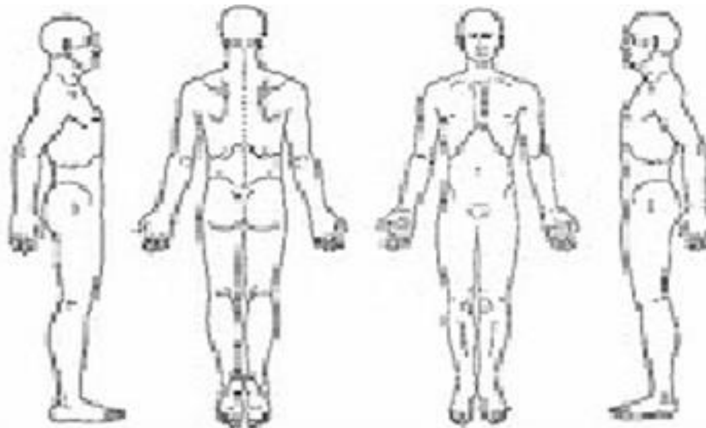
Date of Birth____________ email _________________________________ May we contact you via email? _Y N__

Occupation_______________________________ Sex:(circle one) M F

Emergency Contact _______________________________ Phone (_____)________________

Please take a moment to carefully read the following information and sign where indicated. If you have any specific medical condition or specific symptoms massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

- Have you had a professional massage before? Yes ☐ No ☐ If yes, how recently? __________
- Do you have any particular goals in mind for this massage session? Yes ☐ No ☐
  If yes, please explain ____
- What kind of pressure do you prefer? Light ☐ Medium ☐ Firm ☐
- Are you wearing: Contact lenses ☐ Dentures ☐ Hearing aid ☐
- Do you have any limitations in mobility? Yes ☐ No ☐
  If yes, please describe ____
- Do you have any difficulty lying on your front, back, or side? Yes ☐ No ☐
  If yes, please explain ____
- Have you been sick within the past two weeks? Yes ☐ No ☐
  If yes, please explain ____
- Have you broken any bones in the last two years? Yes ☐ No ☐
  If yes, please explain ____
- Have you ever had any surgeries? Yes ☐ No ☐
  If yes, please explain ____
- Do you experience stress in your work, family, or other aspect of your life? Yes ☐ No ☐
  If yes, how has it affected your health? ____
- Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? Yes ☐ No ☐
  If yes, please identify ____
- Are you currently experiencing any pain? Yes ☐ No ☐
  If yes, on a scale from 1 to 10 how severe is your pain? (circle one) **1 2 3 4 5 6 7 8 9 10**



Circle any specific areas you would like the massage therapist to concentrate on during the session
Place an X anywhere you would like them to avoid

Medical History

In order to plan a safe and effective massage session, some general information about your medical history is needed.

- Are you currently under medical supervision? Yes ☐ No ☐
  If yes, please explain ____
- List any known allergies
  ____
  ____
  ____
- Are you currently taking any medication? Yes ☐ No ☐ If yes, please list

  Name of medicine | Reason for medicine | Last taken

  ____
  ____
  ____
  ____
  ____
- **Please check any condition listed below that applies to you:**

Musculoskeletal
☐ Bone or joint disease
☐ Tendonitis/Bursitis
☐ Arthritis/Gout
☐ Jaw Pain (TMJ)
☐ Spinal Problems
☐ Osteoporosis

Lymph/Immune System
☐ Lymphedema
☐ Crohn Disease
☐ Lupus
☐ Multiple Sclerosis
☐ HIV/AIDS

Circulatory
☐ Heart Condition
☐ Phlebitis/Varicose Veins
☐ Blood Clots
☐ High/Low Blood Pressure
☐ Thrombosis/Embolism

Urinary System
☐ Kidney Stones
☐ UTI
☐ Kidney Disease

Respiratory
☐ Breathing Difficulty/Asthma
☐ Emphysema
☐ Cystic Fibrosis

Digestive
☐ Hepatitis
☐ Irritable Bowel Syndrome
☐ Ulcers

Nervous System
☐ Fibromyalgia
☐ Epilepsy
☐ Peripheral Neuropathy

Endocrine System
☐ Diabetes
☐ Hyperthyroidism/Hypothyroidism

Skin
☐ Eczema
☐ Herpes/Cold Sores
☐ Fungal Infections
☐ Rashes

Reproductive System
☐ Sexually Transmitted Disease
☐ Are you pregnant? How many months? ________________

Psychological
☐ Depression
☐ Anxiety

Other
☐ Open Wounds
☐ Cancer/Tumors
☐ Recent Accident/Injury
☐ Other medical condition not listed
____
____

Please explain any condition that you have marked above
____
____
____
____
____
____

Client Printed Name ____ Date _________________

Client Signature ____Date__________________