

Health Intake Form

Raelene Wilson, RMT

Date _____ Date of Birth _____
Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Email _____

What type of pressure do you prefer? Light Moderate Deep

What are your desired results from massage therapy? _____

What types of physical activity do you engage in? (Work, exercise, etc.) _____

Health Information:

Are you currently under a doctor's care? Yes No

If Yes, Please explain _____

Pregnant? No Yes Weeks (_____)

Please list any medications you are currently taking, including aspirin/pain relievers, vitamins/supplements, birth control pills, etc. _____

List Surgeries/Accidents (including year and treatment received) in the last 5 years. _____

Please look over the list of health disorders and check all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Bone or Joint Disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Athletes Foot |
| <input type="checkbox"/> Broken/Fracture Bones | <input type="checkbox"/> Warts; Location _____ | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Neck/Shoulder/Arm Pain | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Low Back/Hip/Leg Pain | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Herpes/Shingles |
| <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Spasm/Cramps | <input type="checkbox"/> TMJ/Jaw Pain |
| <input type="checkbox"/> Anxiety or Stress | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Cancer/Tumors |
| <input type="checkbox"/> PMS/PMDD | <input type="checkbox"/> Diabetes/Type? _____ | <input type="checkbox"/> Infectious Diseases |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Drug/Alcohol Disorder | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Heart Conditions/Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nicotine/Caffeine Addiction | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Fibromyalgia/Myofascial Pain Syndrome | <input type="checkbox"/> AIDS/HIV | |

If you checked any disorders above please use the next few lines to explain. (dates, areas of disorder/disease, type, symptoms of concern. Please be specific.) _____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or stroke may be adjusted to my level of comfort. I further understand that massage/bodywork 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 that I am aware of. Because massage/bodywork should not be performed under certain medical conditions, 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 during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that the massage therapist reserves the right to refuse to perform massage on anyone whom she deems to have a condition for which massage is contraindicated. I understand that any illicit or sexually suggestive remarks or advances I make will result in immediate termination of the session. I am of lawful age (18) and have read and fully understand the contents of this document and represent myself as physically capable of using the services offered by this therapist.

Signature _____ Date _____

Practitioners Signature _____ Date _____

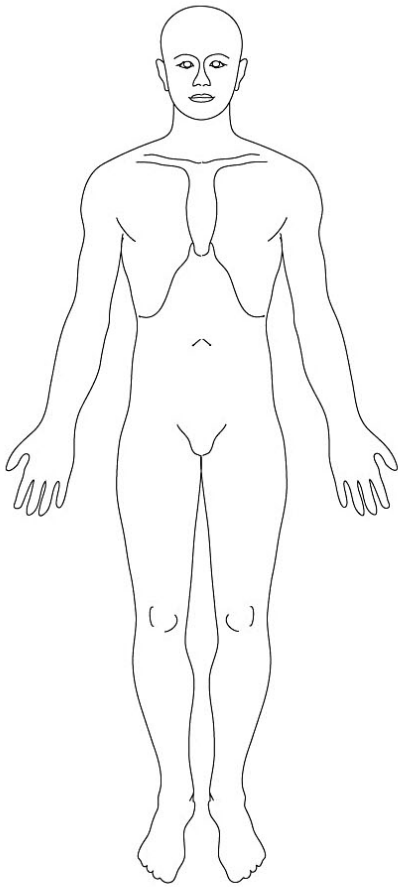
Please indicate any areas you have discomfort or would like me to focus on during your treatment.

P = Pain

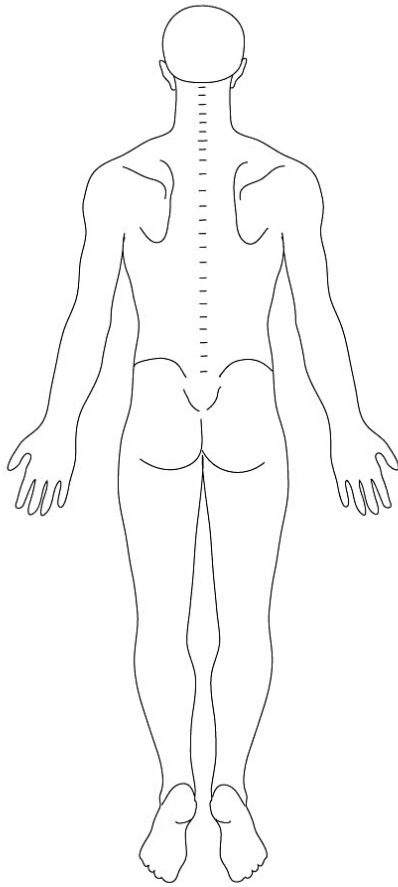
S = Stiffness

N = Numbness

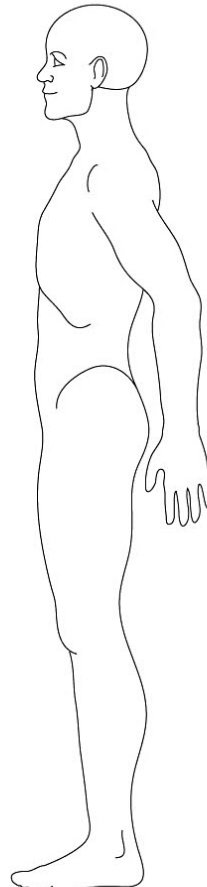
T = Tingling



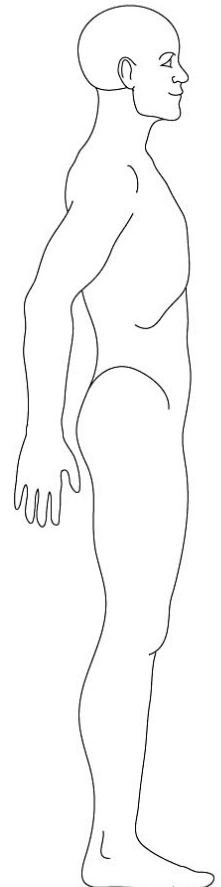
R L



L R



L



R

