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? ____

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

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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.

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

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

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.) ____

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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 = Stiffnesss N = Numbness T = Tingling