

# Confidential

## Massage Therapy Client Intake and Health History Form

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### Contact and Personal Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (w) \_\_\_\_\_ (h) \_\_\_\_\_ (cell) \_\_\_\_\_

Email: \_\_\_\_\_ Birthday(dd/mm/yy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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### Health History

Recreational Activities: \_\_\_\_\_

Are you receiving treatments from other health-care professionals? Yes  No

If yes, what? \_\_\_\_\_

Have you had massage treatments before? Yes  No

What results do you look for in a massage? \_\_\_\_\_

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Are you presently on any medications? Yes  No

If yes, please list: \_\_\_\_\_

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Please indicate if you presently or previously had any of the following symptoms or ailments:

- |                      |                          |                                     |                          |
|----------------------|--------------------------|-------------------------------------|--------------------------|
| High blood pressure  | <input type="checkbox"/> | Digestive disorders                 | <input type="checkbox"/> |
| Low blood pressure   | <input type="checkbox"/> | Topical diseases                    | <input type="checkbox"/> |
| Vascular problems    | <input type="checkbox"/> | Allergies                           | <input type="checkbox"/> |
| Hemophilia           | <input type="checkbox"/> | Asthma                              | <input type="checkbox"/> |
| Blood disorders      | <input type="checkbox"/> | Dizziness                           | <input type="checkbox"/> |
| Headaches, migraines | <input type="checkbox"/> | Kidney disease                      | <input type="checkbox"/> |
| Heart disease        | <input type="checkbox"/> | Cancer                              | <input type="checkbox"/> |
| Liver disease        | <input type="checkbox"/> | Psychological or emotional problems | <input type="checkbox"/> |
| Skin problems        | <input type="checkbox"/> | Arthritis/Osteoarthritis            | <input type="checkbox"/> |

Have you had surgery in the past 5 years? Yes  No

What was the surgery for? When? \_\_\_\_\_

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List any medical implants (pacemaker, pins, etc.) \_\_\_\_\_



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Have you had any accidents, injuries, or trauma in the past 5 years?    Yes     No

If yes, please describe what happened: \_\_\_\_\_

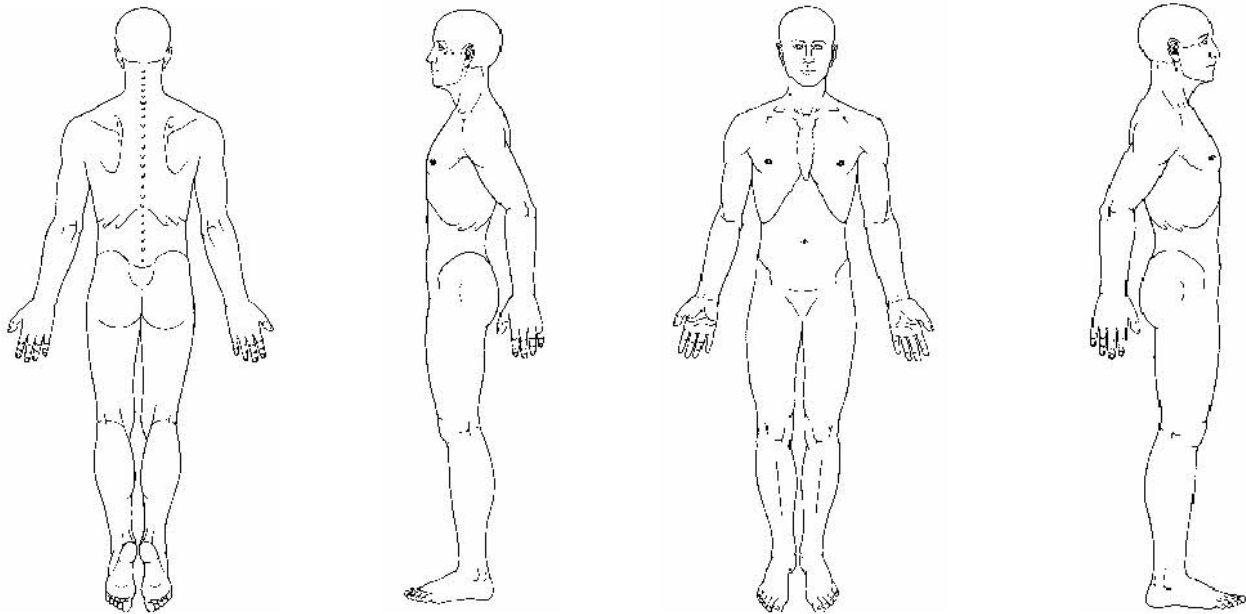
What are your sleep habits? Hours per night? \_\_\_\_\_

Do you have difficulty lying on your back (Yes     No ) or front (Yes     No )?

Are you pregnant?    Yes     No

Describe any other health concerns your Massage Therapist should be aware of: \_\_\_\_\_

Please indicate on the diagram where you are experiencing any soreness or problems:



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### Massage Therapy Informed Consent

I have informed the Massage Therapist of all my known physical conditions, medical conditions and medications and I will keep the Massage Therapist updated on any changes to my health history.

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The Massage Therapist explained to me and I understand:

- the general benefits of massage
- possible massage contraindications
- the treatment procedure
- that massage therapy is not a substitute for medical treatment or medications
- that it is recommended that I work with my Primary Caregiver for any condition I may have
- that a Massage Therapist does not diagnose illness or disease and does not prescribe medications

I \_\_\_\_\_, have read, understood and completed, to the best of my knowledge, the Massage Therapy Client History form and the Massage Therapy Informed Consent form. I release the Massage Therapist from any and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this client history form.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Practitioner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

May we contact you via:    phone     email     text



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