



**THERAPEUTIC SOLUTIONS**  
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**CONFIDENTIAL THERAPEUTIC MASSAGE THERAPY CLIENT HEALTH INTAKE FORM**

NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY/STATE/ZIP \_\_\_\_\_  
 HOME PHONE( ) \_\_\_\_\_ WORK( ) \_\_\_\_\_ CELL( ) \_\_\_\_\_  
 OCCUPATION/EMPLOYER \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 REFERRED BY \_\_\_\_\_ REASON FOR APPOINTMENT \_\_\_\_\_  
 Have you had a professional massage before? Y/N When \_\_\_\_\_ By whom \_\_\_\_\_  
 What did you like/dislike about your previous massage session? \_\_\_\_\_  
 Are you currently under the care of a physician and/or a chiropractor for any reason? Y/N  
 If yes, please explain \_\_\_\_\_  
 Are you currently on any prescribed or OTC medications? Y/N  
 List \_\_\_\_\_

Place a checkmark beside the conditions you are currently experiencing:

- |                        |       |   |       |
|------------------------|-------|---|-------|
| Pregnancy/Nursing      | _____ | High or Low Blood Pressure                | _____ |
| Osteoporosis           | _____ | Fibromyalgia                              | _____ |
| Skin Allergies         | _____ | Multiple Sclerosis                        | _____ |
| Tendonitis or Bursitis | _____ | Cancer/Tumor(s)(past or present)          | _____ |
| Carpal Tunnel          | _____ | Allergies/Sinus/Respiratory Condition     | _____ |
| Scoliosis/H-Rod        | _____ | Seizures/Convulsions/Epileptic Disorder   | _____ |
| Phlebitis/Blood Clots  | _____ | Migraines/ Headaches/Whiplash             | _____ |
| Diabetes               | _____ | Contagious or Infectious Condition        | _____ |
| HIV/Aids Positive      | _____ | Heart Disease or Circulatory Problems     | _____ |
| Varicose/Spider Veins  | _____ | Herniated/Ruptured/Bulging Disc           | _____ |
| Swelling/Bruise Easily | _____ | Facial Reconstruction/Injections/Implants | _____ |
| Spinal Problems        | _____ | Dentures/Contact Lenses/Hearing Aids      | _____ |
| Chronic Pain/Fatigue   | _____ | Elevated Cholesterol                      | _____ |
| Stress/Tension/Anxiety | _____ | Low Back Pain/Sciatica                    | _____ |
| Pinched Nerve/Numbness | _____ | Arthritis/Rheumatoid/Osteoarthritis       | _____ |

Any other medically supervised condition(s)? \_\_\_\_\_

List previous Surgeries, Implants, and/or including Pacemaker \_\_\_\_\_

Suffered Accident, MVA, or Injury within the last 2 years? \_\_\_\_\_