The Retreat Massage & Day Spa

Hands On Health

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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?_____