



The "Zen" Den

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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? _____