

Soothing Elements – New Client Health History Intake

Please take a moment to answer the following questions. The information you provide will be used to customize your session to your particular needs.

Name _____ Date of Birth _____ Referred by: _____

Address _____ City/State/Zip _____

Phone: (Home) _____ (Cell) _____ (E-Mail) _____

Occupation _____ Posture assumed most of day _____

Physician _____ Do we have permission to contact him/her should the need arise? _____

Emergency contact and phone: _____

Please answer the following to the best of your knowledge.

1. Have you had a professional massage before? _____
2. Do you have any allergic reactions to oils, lotions, or other substances put on your skin, or to any nuts? _____
3. Do you have any particular goals for this massage session? _____
4. Daily activities/sports/hobbies: _____
5. Please circle your level of physical activity: None Light Moderate Heavy
6. If you are currently under medical supervision, please explain _____
7. Are you pregnant? _____

Medical History – Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Thank you.

___ Skin condition (acne, athlete's foot, impetigo, open sores, rashes, warts, other):

___ Allergies: _____

___ Lymphatic condition (swollen glands, chronic fatigue, lupus, lymphoma, lymphedema, other):

___ Recent injury or accident (whiplash, sprain, deep bruise, other):

___ **Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis, other):**

___ **Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, other):**

___ **Joint problems, pain or stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other):**

___ **Bone conditions (osteoporosis, previous fracture, cancer, other):**

___ **Headaches (migraines, PMS, tension, cluster, other):**

___ **Emotional difficulties (depression, anxiety, psychotic episodes, other):**

___ **Stress**

___ **Previous surgery, please state type and approximate date** _____

___ **Any other medical considerations:** _____

___ **List any prescription medications you are currently taking:** _____

___ **List any over the counter medications/supplements you are currently taking:** _____
