CLIENT HEALTH HISTORY INTAKE FORM

Name_____ Birthday _____ Today's Date_____
Address _____ City _____ State _____ Zip _____
Daytime Phone_____ Evening Phone _____Occupation _____
E-mail _____
____ Check if you would like to receive our monthly newsletter with periodic specials, info on classes and news.

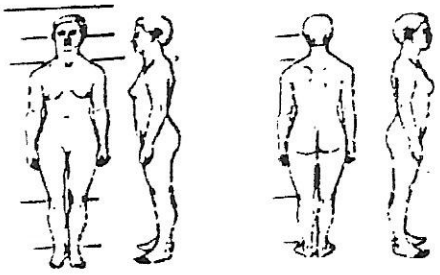
Emergency Contact _____Relation to you_____ Phone number_____

Who may I thank for referring you? _____
Have you ever experienced a professional massage? ❑Yes ❑No
What is the reason for your visit? _____

Are you in pain? ❑ Yes ❑ No
And if yes, mark your current pain level with an "X" below. If yes, mark the location(s) with an "X".

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Severe Pain



How would you rate your overall health? ❑ poor ❑ fair ❑ good ❑ excellent
Your diet? ❑ poor ❑ fair ❑ good ❑ excellent
Your sleep? ❑ poor ❑ fair ❑ good ❑ excellent
How you describe your overall level of stress? ❑Low ❑Medium ❑High
Do you exercise regularly? If so what type and how often? _____
_____
What medications are you currently taking and for what reason? Please include prescriptions, over the counter, herbs and vitamins. _____
_____

Have you been in an accident or suffered any injuries and/or surgeries in the past two years?
_____
_____

Are you pregnant? ❑Yes ❑No If yes, how many weeks? _____
If yes, your estimated due date? _____
❑ singleton ❑ twins ❑ triplets
How many times have you been pregnant? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7+
If you have children, what are their names and ages? _____

Describe your feelings about the pregnancy or postpartum time? _____
_____