KAILO CENTER FOR THE HEALING ARTS
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CLIENT INTAKE AND HEALTH HISTORY FOR MASSAGE THERAPY
CONFIDENTIAL

Name____ Date__________________
Address____
Date Of Birth_____________________ Occupation_____________________________
Telephone (Home)_______________ (Work)_____________ (Cell)_______________
E-Mail Address_______________________ Preferred Means of Contact ____________
Emergency Contact (Name/Phone No.)____
Referred By? ____

1. Have you had massage therapy before? _____________________________________
2. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain____
3. Do you have allergic reactions to any oils, lotions, ointments, or other substances applied to your skin? Yes No
   If yes, please identify and explain____
5. Do you wear contact lenses ( ) dentures ( ) a hearing aid ( )?
6. Do you sit for long periods at a desk, computer, or driving? Yes No
   If yes, please explain____
7. Do you perform any repetitive movements in your work, sports, or hobby? Yes No
   If yes, please explain____
8. Do you require assistance getting on or off the massage table? Yes No
9. Do you experience stress in your work, family, or other aspects of your life? Yes No
   If yes, please describe____
   Do you believe your stress level is Low Medium High Very High
   Do you experience muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other ( ) ?
   Please describe circumstances and symptoms___________________________________
   ____
10. Is there a particular area(s) of the body where you experience tension, stiffness, pain, or other discomfort? Yes No
   If yes, please identify____
11. Are you currently under medical supervision? Yes No
   If yes, please explain____
12. Are you currently taking any prescription or herbal medication? Yes No
   If yes, please list____
   Physician's Name/Phone No.____
   Permission to contact? (Signature Required)__________________________________

Confidential Intake and Health History (2)
Client Name____

13. Please note level and type of your exercise or physical activity:
____
____

14. Please check any condition below that applies to you: (Elaborate as necessary)

___ Skin condition (eg, acne, rash, psoriasis, allergy, easy bruising, contagious condition)

___ Allergies (Note: ____)

___ Recent accident, injury, surgery (eg, whiplash, sprain, broken bone, deep bruise)

___ Muscular problem (eg, tension, cramping, chronic soreness, spasm, tremor)

___ Joint problem (eg, osteoarthritis, rheumatoid arthritis, dislocation, joint replacement)

___ Lymphatic condition (eg, swollen glands, lymphedema, lymphoma, nodes removed)

___ Circulatory conditions (eg, atherosclerosis, varicose veins, phlebitis, anemia)

___ Circulatory-Other (heart attack, arrhythmias, blood pressure concerns, hemophilia)

___ Neurologic (stroke, sciatica, epilepsy, multiple sclerosis, cerebral palsy, numbness)

___ Digestive (eg, ulcer, colitis, Crohn’s Disease, acid reflux, constipation, diarrhea)

___ Immune System (chronic fatigue, HIV/AIDS, other ______________________)

___ Skeletal System (osteoporosis, bone cancer, spinal injury, other ____________)

___ Endocrine (diabetes, other glandular disorders __________________________)

___ Headache (tension, migraine, cluster)

___ Cancer (currently, or previously ____________________________________)

___ Emotional (depression, anxiety, panic attacks, traumatic incidents)

___ Prior surgery, disease, or condition that may be affecting you now

___ Cosmetic Surgery (Note: ____)

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Massage Therapy Informed Consent

I have read and understood this Client Intake and Health History form in its entirety. If at any time there are changes in the information given, or in my condition, I will notify the therapist and update this form before receiving additional massage. I have stated all my known medical conditions and have answered all questions honestly. If there is any information not directly requested on this form, which would compromise my ability to safely receive massage, I am responsible for bringing that information to the therapist's attention by noting it here: ____

The massage treatment I am requesting is for the purpose(s) of relaxation, stress reduction, relief from muscle tension or spasm, to improve range of motion, circulation, or energy, and to receive a positive experience of touch.

I understand the massage therapist does not diagnose or prescribe for medical illness, disease, or other disorders, and that spinal manipulations are not part of massage therapy. I further understand that massage therapy is not a substitute for medical examination or diagnosis, and that I take responsibility for consulting with my physician for any ailment or condition of concern to me. If I experience any pain or discomfort during the massage session, I will immediately communicate that to the therapist so that treatment can be adjusted accordingly.

I understand that my feedback is an essential element in my treatment. If at any time I become uncomfortable during the massage, I may bring that to the therapist's attention and request that the session be modified, temporarily suspended, or brought to an end. However, I can ask that a session be discontinued at any time, for any reason, and the therapist will honor that request.

Unless in emergency or inclement weather, I acknowledge that if I am unable to keep a scheduled appointment, 24 hours notice is required or I may be charged for the time reserved.

I have reviewed this form, and the information contained in my Client Intake and Health History, with the massage therapist. By my signature, I consent to receive massage therapy.

____	___________________________
Client's Signature	Date
____	___________________________
Therapist's Signature	Date