Valley Massage Therapy
Client Health Form

Name _____ D.O.B. _____ Date _____

Last First Middle Initial

Home Phone _____ Cell _____ **Is it ok for me to email and text you?**_____

Address _____

City State Zip

Email _____ Occupation _____

Have you received a massage before? **If so, when and what were the results?**

Reason for today's visit:

Specific Injury Treatment Past Event Treatment Stress Reduction Relaxation Other

Do any areas of your body need special attention?

Is this concern: Minor Problematic Major Recurring Getting worse Getting Better

Are there any areas that should be avoided?

Have you had this concern/problem before? When did you first notice pain/discomfort?

Are you under the care of a physician? If so, what for? Please include the physician's name and number.

Please list current medications including drugs (prescribed and over-the-counter), homeopathic remedies and supplements.

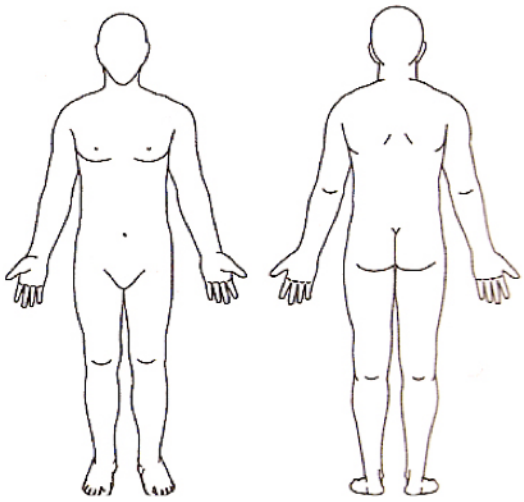
Allergies/sensitivities: Oils Food Scents Detergents Animals other

Stress reduction/ exercise activities: _____ Frequency: _____

Check any of the following that apply to your current health:

Pregnancy	Heart conditions	Circulatory conditions	Blood Clots	Diabetes
Infections	Cancer	Difficulty Breathing	Arthritis	Allergies
Fever	Headaches	Inflammation	Sleep Problems	

Mark on Figures all areas of:
Pain, tenderness with **O** (circle)
Numbness, tingling with **Z**
Swelling or stiffness with **X**
Bruises, open wounds with **W**



Rate severity of all symptoms areas from 1-10
(1 = mild, 10 = Put me out of my misery)

1 2 3 4 5 6 7 8 9 10

CONTINUED ON BACK SIDE

Previous History
If applicable please describe type and date

Surgeries _____

Accidents _____

Major Illness _____

Do you have any questions, special requests or concerns?

How did you hear about us?

If under the age of 18:

Name of Guardian_____ Relationship_____

Contact (H)_____ (W)_____ (C) _____

Consent for Care
I have read and understand this intake form and have completed it to the best of my knowledge and consent to this massage therapy session. I understand that massage therapy is a therapeutic health aid for the purpose of stress reduction and relief from muscular tension and is non-sexual. I understand that massage therapist do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examinations or diagnosis, and that it is recommended that I see a Primary Health Care Provider for any physical ailment I may have.

Cancellation Agreement
In consideration of my fellow patients and my massage therapist time, I understand that a minimum of **48 hours notice** is required to change or cancel an appointment. I further acknowledge that appointments missed or cancelled within the 48 hour time period are subject to the regular massage fee unless I send someone in my place. In case of an emergency, I will call as soon as possible to reschedule my appointment and no cancellation fee will be expected.

By my signature I confirm that I have read the aforementioned policies and agree to the terms set out.

Signature _____ Date _____

Have you been vaccinated, if so when? _____

_____

_____

_____

39 Main Street, Suite 34A, Third Floor
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Free parking located in the old court personnel parking lot behind the building.