**Health History Intake Form**

Caitlin Granier, LMT

**Basic Information**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cellphone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you prefer to be reached?: text message \_\_\_\_\_ phone call \_\_\_\_\_ email \_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Background**:

Are you currently under the care of a physician or other health care provider? (including Chiropractor, Physical Therapist, Osteopath, etc.). yes \_\_\_ no \_\_\_

If yes, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do I have permission to contact your health provider if needed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, Provider(s)’s name and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeing a counselor or attend support group meetings?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently exercise or practice stress reduction activities? If yes, please include frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Please indicate if you currently experience, or have experienced any of the following*:

**Cardiovascular Digestive** **Neurological** **Autoimmune**

\_\_ High Blood Pressure \_\_ IBS \_\_ Migraine/Headaches \_\_ Diabetes

\_\_ Low Blood Pressure \_\_ Diverticulitis \_\_ Spinal Cord injury \_\_ Lupus

\_\_ Stroke \_\_ Ulcers \_\_ Neuropathy \_\_ Fibromyalgia

\_\_ Blood Clots \_\_ Acid Reflux \_\_ Bell’s Palsy \_\_ Thyroid issues

\_\_ Varicose veins \_\_ Crohn’s disease \_\_ Multiple Sclerosis \_\_ Restless Leg Syndrome

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin/Allergies Muscoloskeletal Other System Disorders**

\_\_ Nut oils \_\_ Pain, numbness, or burning \_\_ TMJ disfunction \_\_ Lymphedema / edema

\_\_ Seasonal \_\_ Sciatica/ piriformis syndrome \_\_ Plantar fasciitis \_\_ Lung

\_\_ Skin sensitivity \_\_ Spinal disc issues \_\_ Frozen Shoulder \_\_ Urinary or Kidney

\_\_ Contagious condition \_\_ Tendinitis, bursitis, or arthritis \_\_ Broken bones \_\_ Liver / gallbladder

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Joint pain \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_ \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_

\_\_ **Visual and Auditory**: \_\_ Contacts \_\_ Tinnitus \_\_ Deafness \_\_ Partial Loss \_\_ Hearing Aids

\_\_ **Cancer** Where in the body? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Diagnosis(es): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have (please circle all that apply): Radiation, Chemotherapy, Surgery, Lymph Node removal?

Other Treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ **Pregnant or given birth in the last year** \* if yes, please request Prenatal Form

\_\_ **Injuries, Surgeries, Car Accidents** (if yes, please list with approximate date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is there anything else about your physical, mental, or emotional state your therapist should know before the session not listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medication you are currently taking, and any you have taken in the past 3 months (include prescriptions, OTC, and/or herb supplements):

Medication/supplement: Reason for taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* if any additional, please use the back

**Massage Therapy Preferences**:

Have you ever had a professional massage before? yes \_\_\_ no \_\_\_ date of last massage: \_\_\_\_\_\_\_\_\_\_\_

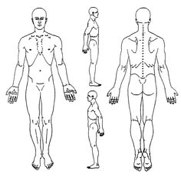
If yes, is there anything you liked or disliked from previous massages?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any issue laying on your front, back, or side? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary reason for today’s session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any areas of discomfort, or for specific focus:



I attest that all the above information is true to my knowledge. I understand massage therapy is meant to compliment and in no way replace a doctor or other health professional’s care when needed. I understand my massage therapist may discuss but cannot diagnose a condition, or may suggest but not prescribe therapies, supplements, or other remedies for my health. I agree to keep my therapists up to date on any changes to my health, understanding that certain medical conditions are not best suited for massage.

I understand that this therapy is completely non-sexual. Any illicit or suggestive remarks or advances will result in a termination of the session, and I will be responsible for payment for the scheduled appointment.

I attest that I wish to receive massage therapy at my own will, and that I feel my body is in a state of health that would allow me to benefit from receiving this therapy.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_