Massage Intake Form

Name_____Date_____Age ____Birth date _____

Address_____City_____ST_____ZIP _____

Phone_____Email_____Sex_____

Occupation_____Employer _____

Emergency Contact_____Phone_____

Primary Physician_____Phone_____

Current Medications_____

_____

Are you pregnant or nursing? Yes No

PLEASE INDICATE WITH AN X IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

	AIDS/HIV		HIGH CHOLESTEROL
	ANXIETY		HIGH BLOOD PRESSURE
	ANEMIA		INSOMNIA
	APPENDICITIS		KIDNEY DISEASE
	ARTHRITIS		MIGRAINE HEADACHE
	ASTHMA		MISCARRIAGE
	BLOOD DISORDERS		MULTIPLE SCLEROSIS
	CANCER		OSTEOPOROSIS
	CHEMICAL DEPENDENCY		PACEMAKER
	CHICKEN POX		PARKINSON'S DISEASE
	DIABETES		PNEUMONIA
	EMPHYSEMA		PROSTHESIS
	FIBROMYALGIA		SEIZURES
	GOUT		SPINA BIFIDA
	HEART DISEASE		STROKE
	HEPATITIS		TUBERCULOSIS
	HERNIA		ULCERS