Infinite Healing Center
2509 S. Power Road #115 Mesa, Arizona 85209

Massage Therapy Client Intake Form

Date:_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Cell carrier to receive a text message for confirmation calls:_____

Email Address: _____

Date of Birth:_____/_____/_____ Sex: ☐Male ☐Female **Marital Status**: ☐Single ☐Married ☐Other

How did you hear about us?_____

In case of Emergency, Please Notify:

Name:_____ Telephone #:_____

What are your goals for this treatment?_____

Present Symptoms: What is your major complaint or condition you want to improve?_____

What activities and products have you used to address this condition?_____

Are you under medical/therapeutic treatment? ☐ Yes ☐No **If yes, for what condition?**

_____ _____

List any medications (including Aspirin) and nutritional supplements you are taking:

_____

Specify any known allergies: _____

Please list any additional comments regarding your skin care or general well being:

_____

I understand that as a massage client, I am required to give ***at least twenty-four (24) hours notice*** to a cancellation prior to my scheduled massage. I also understand that if I do not give at least twenty-four hours notice that I will be ***charged a fee of $25 an hour.*** This cancellation policy has been implemented with the hopes of alleviating the amount of last minute cancellations and no-shows that happen, which directly affect the stability of the massage therapists' income. **PLEASE INITIAL _____**

Health History

Check the following conditions that apply to you, past and present.
Please add your comments to clarify the condition.

Musculo-Skeletal
☐Headaches
☐Joint Stiffness/Swelling
☐Spasms/Cramps
☐Broken/Fractured Bones
☐Strains/Sprains
☐Back, Hip Pain
☐Shoulder, Neck, Arm, Hand Pain
☐Leg, Foot Pain
☐Chest, Ribs, Abdominal Pain
☐Problems walking
☐Jaw Pain/TMJ
☐Tendonitis
☐Bursitis
☐Arthritis
☐Osteoporosis
☐Scoliosis
☐Bone or Joint Disease
☐Other: _____

Circulatory and Respiratory
☐Dizziness
☐Shortness of Breath
☐Fainting
☐Cold Feet or Hands
☐Cold Sweats
☐Swollen Ankles
☐Pressure Sores
☐Varicose Veins
☐Blood Clots
☐Stroke
☐Heart Condition
☐Allergies
☐Sinus Problems
☐Asthma
☐High Blood Pressure
☐Low Blood Pressure
☐Lymphodema
☐Other: _____

Skin
☐Rashes
☐Allergies
☐Athlete's Foot
☐Warts
☐Moles
☐Acne
☐Cosmetic Surgery
☐Other: _____

Digestive
☐Nervous Stomach
☐Indigestion
☐Constipation
☐Intestinal Gas/Bloating
☐Diarrhea
☐Diverticulitis
☐Irritable Bowel Syndrome
☐Crohn's Disease
☐Adaptive Aids
☐Other: _____

Nervous System
☐Numbness/Tingling
☐Twitching of Face
☐Fatigue
☐Chronic Pain
☐Sleep Disorders
☐Ulcers
☐Paralysis
☐Herpes/Shingles
☐Cerebral Palsy
☐Epilepsy
☐Chronic Fatigue Syndrome
☐Multiple Sclerosis
☐Muscular Dystrophy
☐Parkinson's Disease
☐Spinal Cord Injury
☐Other: _____

Reproductive System
☐Pregnancy:
☐Current ☐Previous
☐PMS
☐Menopause
☐Pelvic Inflammatory Disease
☐Endometriosis
☐Hysterectomy
☐Fertility Concerns
☐Prostate Problems

Other
☐Loss of Appetite
☐Forgetfulness
☐Confusion
☐Depression
☐Difficulty Concentrating
☐Drug Use _____
☐Alcohol Use _____
☐Nicotine Use _____
☐Caffeine Use _____
☐Hearing Impaired
☐Visually Impaired
☐Burning Upon Urination
☐Bladder Infection
☐Eating Disorder
☐Diabetes
☐Fibromyalgia
☐Post/Polio Syndrome
☐Cancer
☐Infectious Disease(please list)
_____
☐Other Congenital or Acquired Disabilities (please list)
_____
☐Surgeries _____
☐Other: _____

Please list any additional comments regarding your health and well-being: _____
_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's Signature: _____ Date: _____