

# University of New Hampshire Health Services

## Massage Therapy Intake Form

*In completing your massage therapy intake form, it is important that you disclose any medical conditions and concerns you may have. There are certain situations in which massage therapy is contraindicated, meaning it is not recommended, when administered to a person with specific medical conditions. Sometimes a condition will require a medical provider's clearance before services are provided, but often our skilled therapists can modify their treatment to accommodate your condition. At the time of your appointment, your massage therapist will review your intake form with you and discuss any medical conditions and concerns you may have to determine if massage therapy is appropriate and safe.*

**Please complete this confidential form prior to your massage therapy appointment. Not all questions are pertinent to every client's situation.**

**PERSONAL DATA**

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

Date of Birth \_\_\_\_\_ ID Number \_\_\_\_\_

**HEALTH HISTORY**

Is this your first professional massage?       Yes     No

What would you like from your massage today? \_\_\_\_\_

Any areas of your body to focus on? \_\_\_\_\_

Any areas of your body to avoid? \_\_\_\_\_

Were you referred by a health care provider?  Yes     No

If referred, please indicate by who and specialty: \_\_\_\_\_

**Current Health:** Are you currently experiencing or have any of the following (please ✓) :

Tension or soreness in a specific area	Overuse injury pain	
TMJ syndrome and/or teeth grinding	Accident or other injury pain	
Numbness or tingling	Chronic pain	
Frequent headaches	Shooting or stabbing pain	
Cardiac or circulatory problems	Neck pain	
Muscle trigger points	Back pain	

If you ✓ any of the boxes above, please explain: \_\_\_\_\_

Please list any medications you are taking and reasons for use: \_\_\_\_\_

Please list any supplements, herbs and/or vitamins you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
Please list any allergies or sensitivities you have: \_\_\_\_\_  
\_\_\_\_\_

Do you wear contacts?      Yes    No

**(OVER)**

**Pain Assessment (if applicable):** On a scale from 0-10, 10 being the worst, please rate your pain:

Current Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Least Pain	0	1	2	3	4	5	6	7	8	9	10

Please describe where you feel the pain: \_\_\_\_\_

**Medical Conditions:** Are you currently affected by or have experienced in the last two years (please ✓):

Accidents	Anemia	Anxiety
Arthritis	Asthma	Bladder problem(s)
Blood clot	Bone fracture	Bowel problem (s)
Cancer	Chronic fatigue	Contagious illness
Depression	Diabetes	Epilepsy
Fever	Fibromyalgia	Heart condition
High blood pressure	Hospitalization	Injuries
Joint strain/sprain	Multiple Sclerosis	Pregnancy
Skin problems (sunburn, rash, acne)	Stroke	Surgery
Other		

If you ✓ any of the medical conditions above, please explain: \_\_\_\_\_  
\_\_\_\_\_

***I understand that massage services are offered to be a health aid and are in no way meant to take the place of a health provider's care when it is indicated. Information exchanged during massage sessions is educational in nature and intended to help me become more familiar with my own health status.***

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

Reviewed by: \_\_\_\_\_

\_\_\_\_\_  
Signature of massage therapist

\_\_\_\_\_  
Date