Balanced body
massage therapy

18927 33rd Ave W Suite B, Lynnwood, WA 98036
Ph: 425.776.1177 | Fax: 425.776.5533

Health Intake Form

Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Phone _____ Work _____ Cell _____

Email _____

Occupation/Employer _____

Emergency Contact & Phone _____

Answer the following questions by circling yes or no and provide any other necessary information.

YES NO Have you ever had a professional massage?

YES NO Are you currently under the care of a health care provider for a specific condition?

_____

YES NO Do you take supplements or medication (asprin, aleve, etc?) Please list medications, dosages and conditions

_____

YES NO Do you have any allergies? _____

YES NO Do you have or have you ever had cancer? _____

YES NO Do you have or have ever had a heart condition? _____

YES NO Have you ever had surgery? If so, when? _____

YES NO Do you have varicose veins, blood clots or circulatory issues? _____

YES NO Do you have high or low blood pressure? _____

YES NO Do you have diabetes? Is it controlled? _____

YES NO Do you have arthritis? Which type? Location? _____

YES NO Do you have issues with depression, anxiety, etc? _____

YES NO Do you have joint or bone issues? If so, where? _____

YES NO Are you experiencing any changes in sleeping pattern? _____

YES NO Do you have any infectious/contagious diseases? _____

YES NO Are you pregnant? If so, what stage? _____

YES NO Are there any medical conditions that your therapist should be aware of prior to treatment?

_____

If you have any needs that require special attention please let you therapist know so that we may serve you better. If there are any questions or concerns at any time before, during or after your treatment inform your therapist immediately.

I understand that massage therapists do not diagnose illness, disease or any other physical or mental disorders. Massage therapists do not prescribe pharmaceuticals or medical treatment. It has been made clear to me that massage therapy is not a substitute for a medical examination and is recommended that I see a physician for any ailments I may suffer from. I have stated all of my known medical history and conditions and I am responsible for communicating any changes in my physical and mental health to my therapist.

Signature: _____ **Date:** _____