Amelia Schaaf Massage Therapist Lic. #18014
541-727-2056

Client Intake and Health History Form

Name: _____ E-mail: _____

Address, City, State, Zip: _____

Best phone number to contact you: _____ Is it okay to leave a message? _____

Date of birth: _____ Occupation: _____

Hobbies and typical daily activities: _____

Emergency contact name and phone number: _____

How are you feeling today? _____

Have you had any recent injury or illness? If yes, please describe: _____

Have you ever had surgery? If yes, please describe: _____

Are you under a physician's care? If yes, please describe: _____

_____

Are you taking any medication? If yes, please describe: _____

_____

Please check any of the following conditions you might have and give additional information if necessary:

○ Allergies - To what?	○ Headaches - How often?	○ Blood pressure issues - High/low?
○ Skin rashes	○ Varicose veins	○ Tension
○ Contagious illness	○ Circulatory problems	○ Insomnia
○ Open sores	○ Spasms/cramps	○ Emotional concerns
○ Fever	○ Sprains/strains	○ Cancer history
○ Dizziness	○ Fractures	○ Heart problems
○ Fatigue	○ Joint stiffness/swelling	○ Kidney or liver disease
○ Pain	○ Osteoporosis	○ Pregnant - How far along?

Additional health information:_____

_____

_____

Are you here primarily for relaxation or clinical treatment of a condition? _____

Are there any areas you would like me to focus on? _____

Are there any areas you would like me to avoid? _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the massage therapist of any changes in my status. I understand that any information shared by my massage therapist is not meant to diagnose or prescribe and that any medical concerns that I have are to be treated by my physician or other licensed healthcare provider.

Client's Signature: _____ Date: _____

Revised 8/11