Sora Massage

Health History Intake Form

Name _____ Phone _____ Today's Date_____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Email_____

Primary Physician _____ Emergency Contact _____

Relationship _____ Phone (c)_____ (h)_____

How did you hear about us?_____

*Have you had a professional massage before? ☐ yes ☐ no

*What type of service are you seeking?

☐ Relaxation ☐ Therapeutic ☐ Bowenwork

*Do you have any allergies or sensitivities to essential oils or lotions? ☐ yes ☐ no

*Please explain_____

*What pressure do you prefer?

☐ Light ☐ Medium ☐ Firm

*Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

*Please explain _____

Please check all that apply:

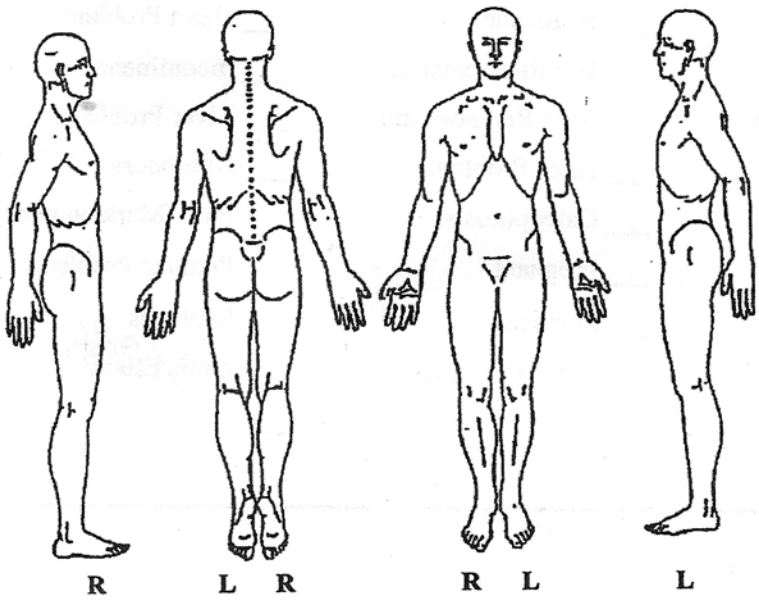
__Abdominal/digestive problem
__Allergies/hay fever
__Arthritis – (location):
_____
__Asthma
__Ankle problem
__Back pain -(location):
_____
__Bed wetting (children)
__Bone spurs
__Breast lump
__Breast pain
__Breast implants
__Bronchitis
__Bunion
__Bursitis
__Buttock pain
__Cancer
__Carpal tunnel syndrome
__Chest pain
__Colic (baby)
__Constipation
__Diabetes
__Diaphragm pain/tightness
__Diarrhea
__Dizziness
__Ear or eye problem
__Edema, general
__Elbow pain, tennis or golf
__Fatigue, chronic
__Fibromyalgia/polymyalgia
__Fibroids - (location):
_____
__Fracture
__Fallen on tailbone/coccyx
__Gall bladder problem
__Heating pad/ice pack usage
__Heating/cooling salve usage
__Hammer toes
__Hamstring pain/tightness
__Headaches
__Heart problem
__Hernia
__Hip pain
__Hip replacement
__Incontinence / bladder
__Infertility
__Jaw / TMJ problem
__Joint replacement
__Knee problem
__Liver Problem
__Lung Problem
__Magnet usage
__Migraines
__Numbness -(location):
_____
__Orthodontia, extensive
__Orthotics in shoes
__Osteoporosis
__Pain, other -(location):
_____
__Pelvic pain
__Plantar fasciitis/neuroma
__PMS/menopause
__Pregnancy
__Prostate problem
__Rib pain/subluxation
__Sacral pain
__Sciatica
__Scoliosis
__Shin splints
__Shoulder problem
__Sinus problem
__Sleep/energy problem
__Tinnitus
__Uterine/ovary problem
__Wrist/thumb pain
__ Other:

Are you currently taking any medication? ☐ yes ☐ no
If yes, please list:

_____

_____

Please mark areas of discomfort or pain



Neck ROM:
L

R

TMJ:

Shoulder ROM:

L

R

Pain intensity scale – choose one
(2) Mild pain (annoying, nagging)
(4) Discomforting (troublesome, numbing)
(6) Distressing (miserable, agonizing, gnawing)
(8) Intense (cramping, dreadful, horrible)
(10) Excruciating (tearing, crushing, unbearable)

Recent hands-on modalities received: _____

I have stated, to the best of my knowledge, my known medical conditions. I understand that massage/ Bowenwork is given for the purpose of stress reduction, relief from muscular tension and/or spasm, facilitation of circulation and energy flow, and relief from stiffness. I understand that the therapist does not diagnose illness or disease, nor treat specific physical or mental disorders. I will inform my therapist of any changes in my condition, and will contact my therapist should I have any concerns.

Client Signature_____Date_____

Therapist Signature _____Date _____