**Central Coast Therapeutic Massage** **Maria Elsea, B.A., C.M.T.**
**(805) 550-4536** **777 Pismo St., San Luis Obispo**

# Confidential Health Intake Form

Name ____________________________________________ Referred By ______________________

Phone (Primary) ________________ (Other) ________________ Email _______________________

Address ________________________________________ City ____________________Zip ________

Ever had a massage? **Yes** **No** When was the last one? __________________ DOB___/___/____

Occupation___________________________________ Are you Right or Left handed? **R** **L** **Ambi**

Please circle if you have or have had any of the following with in the last 10 years

| | | | |
|---|---|---|---|
| □Back Pain: | □Car Accident | □Neck Pain | □Stress |
| □Upper □Mid □Low | □Shoulder Pain | □Sinus Problems | □Depression |
| □Pain Down Legs (Sciatica) | □Knee Pain | □Allergies | □Cancer |
| □Frequent Headaches | □Leg Pain | □Carpal Tunnel | □AIDS |
| □Skin disorders/Rashes: | □Foot Pain | □Tendonitis | □Hepatitis |
| □Athletes foot □ Other | □TMJ | □Dizziness | □Herniated Disk |
| □High/Low Blood Pressure | □Varicose Veins | □Difficulty Breathing | □Anemia |
| □Diabetes | □Kidney Problems | □Swelling | □Arthritis |

Exercise regularly? **Yes** **No** Stretch regularly? **Yes** **No** Any chance of pregnancy? **Yes** **No**
Ever been sore after a massage? **Yes** **No** **N/A** Being treated by a doctor/therapist? **Yes** **No**
If so, for what? ___________________________________ Medications_______________________
Anywhere sensitive or ticklish?________________ Sensitive to heat? **Yes** **No** **Don't know**

What pressure do you prefer? **Light** **Medium** **Medium-Deep** **Deep** **Don't know**

Depending of necessity, may I use essential oils and/or muscle comfort creams to aid the therapeutic process? **Yes** **No** May I use Hot stones? **Yes** **No**

What results would you like from this massage?_________________________________________

Consent for body work on: □ **All Areas Below**
□Back □Gluteals □Legs □Feet □Arms □Hands □Neck □Face □Head

Please feel free to specifically request work on any area, even if it is not indicated here on the form ________________________________________________________________

I understand that it is my choice to receive Massage Therapy. I understand that Massage Therapy is a non-sexual therapeutic massage given with the aim at reducing stress and relief for minor tension, pain, or spasm. To the best of my knowledge I have provided accurate information concerning my personal health. I acknowledge that Massage Therapists do not diagnose or treat medical conditions. Any health concerns should be brought to the attention of my health care provider, and if I have any concerns I have received approval for massage therapy from my doctor. I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

Signature_____________________________________________ Date ______/______/_______