

**EDMONDS MASSAGE CENTER**  
**CONFIDENTIAL HEALTH INTAKE FORM**

NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Please answer the following questions by circling yes or no and provide any necessary clarifications.

- YES NO Have you ever had a professional massage?  
YES NO Do you exercise regularly or participate in any sports? What kind and how often?  
\_\_\_\_\_  
YES NO Are you currently under the care of any other health care provider for a specific condition?  
YES NO Do you take any vitamins, minerals, or medication (including aspirin or ibuprofen) Please list medication, dosage, and condition \_\_\_\_\_  
\_\_\_\_\_  
YES NO Have you ever had surgery? Please list date(s) and procedure(s) \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have or have you ever had cancer? What type and when? \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have or have you ever had heart problems? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have high or low blood pressure? Please circle one.  
YES NO Do you have varicose veins, blood clots or any other circulatory conditions not mentioned? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have diabetes? How is it controlled? \_\_\_\_\_  
YES NO Do you have arthritis? Osteoarthritis or Rheumatoid? (please circle one) Where is it located? \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have bone or joint problems? Please describe: \_\_\_\_\_  
YES NO Do you experience prolonged episodes of depression or other emotions?  
YES NO Do you have any infections or contagious diseases? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
YES NO Are you experiencing any sleep disorders or changes in normal sleeping patterns? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
YES NO Are you pregnant? What stage? \_\_\_\_\_  
YES NO Do you wear contacts, dentures, or hearing aids? \_\_\_\_\_  
YES NO Do you have any other medical conditions your therapist should be aware of before you receive massage? \_\_\_\_\_  
YES NO Do you have any needs that require special attention? Please explain: \_\_\_\_\_  
\_\_\_\_\_

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**Please read carefully, sign, and date.**

I understand that massage therapists do not diagnosis illness, disease or any other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that is recommended that I see a physician for any ailment I may have. I have stated all my known medical conditions and I am responsible to inform my massage therapist of any changes in my physical or mental health. I understand that my massage therapist is an independent contractor at Edmonds Massage Center, LLC. I indemnify and hold harmless Edmonds Massage Center, LLC from any loss or liability arising from services provided by my massage therapist.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_