HORIZON
MASSAGE THERAPY

Confidential Health Intake Form

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone(s) (home, cell, work) _____

Email _____ Okay to contact by email? ☐ Yes ☐ No

Occupation: _____ Employer _____

Referred to Horizon by: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Provider Name: _____

PCP Phone: _____ PCP Fax: _____

I give my massage therapist permission to consult with my health care providers regarding my health and treatment. Comments: _____

Initials: _____ Date _____

Medical History and Information

List and explain, including dates and treatment received:

Surgeries / Injuries _____

_____

Major Illnesses _____

_____

List current medications / herbs / vitamins: _____

_____

What are your main activities at work?

☐ On phone ☐ Sitting ☐ Computer Work ☐ Driving ☐ Walking ☐ Standing

☐ Other: _____

List regular physical activities in which you participate: _____

_____

Have you received massage therapy before? ☐ Yes ☐ No If yes, frequency? _____

Check all current and previous conditions (explain as necessary).

General

Current	Past	
☐	☐	Headaches
☐	☐	Pain
☐	☐	Sleep disturbance
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Sinus

Muscles and Joints

Current	Past	
☐	☐	Rheumatoid Arthritis
☐	☐	Osteoarthritis
☐	☐	Osteoporosis
☐	☐	Scoliosis
☐	☐	Broken bones
☐	☐	Spine/disc issues
☐	☐	TMJ, Jaw pain
☐	☐	Spasms, cramps
☐	☐	Sprains, strains
☐	☐	Tendonitis, bursitis
☐	☐	Joint pain
☐	☐	Muscle pain
☐	☐	Neck, shoulder pain
☐	☐	Low back, hip pain
☐	☐	Other

Nervous System

Current	Past	
☐	☐	Head injuries
☐	☐	Dizziness
☐	☐	Numbness, tingling
☐	☐	Sciatica
☐	☐	Chronic pain
☐	☐	Depression
☐	☐	Other

Respiratory, Cardiovascular

Current	Past	
☐	☐	Heart disease
☐	☐	Blood clots
☐	☐	Stroke
☐	☐	High / Low blood pres
☐	☐	Irregular heart beat
☐	☐	Poor circulation
☐	☐	Swollen ankles
☐	☐	Varicose veins
☐	☐	Shortness of breath
☐	☐	Chest Pain
☐	☐	Asthma

Cancer / Tumors

Current	Past	
☐	☐	Benign
☐	☐	Malignant

Skin Conditions

Current	Past	
☐	☐	Rashes
☐	☐	Athlete's foot, warts
☐	☐	Other_____

Allergies

Current	Past	
☐	☐	Scents, oils, lotions
☐	☐	Detergents
☐	☐	Other_____

Digestive / Elimination System

Current	Past	
☐	☐	Bowel problems
☐	☐	Gas, bloating
☐	☐	Bladder problems
☐	☐	Abdominal pain
☐	☐	Other_____

Endocrine System

Current	Past	
☐	☐	Thyroid
☐	☐	Diabetes

Reproductive System

Current	Past	
☐	☐	Pregnancy
☐	☐	Painful menses
☐	☐	Fibrotic cysts

COVID-19 Screening

Please check if you have had or currently have any of the following symptoms. You will be asked about these symptoms prior to **each** massage.

- ☐ Fever or chills
- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Fatigue
- ☐ Muscle or body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Contact with someone either diagnosed with COVID-19 or suspected of having it

Contract and Consent for Treatment

Please read the following statements carefully and initial after each one.

I understand that screening certain health markers such as temperature, pulse, and blood oxygen levels can help detect early signs of illness and prevent further spread of illness. I agree to let HMT therapists check my temperature via a contactless thermometer and to check my pulse and blood oxygen levels via a pulse oximeter. _____ (initial)

I understand that if any of my health markers are abnormal, or if I report any symptoms indicating possible COVID-19, my massage will be cancelled. _____ (initial)

I understand that close contact with people increases the risk of infection from COVID-19; I also understand that many people remain asymptomatic with COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and consent to receive massage treatment. _____ (initial)

I understand the importance of letting my massage therapist know if I have had contact with anyone infected with COVID-19 in the last month and agree to inform my therapist as needed. _____ (initial)

I understand that my name and contact information might be shared with the WA health department in the event that a client or practitioner at this facility tests positive for COVID-19. _____ (initial)

I agree to notify HMT if I develop any symptoms of and/or am diagnosed with COVID-19 in the two weeks following my appointment. _____ (initial)

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my massage therapist and other members of my health care team, and my experience of those suggestions. I expect my massage therapist to provide safe and effective treatment.

It is my choice to receive manual therapy, and I give my consent to receive treatment. I understand the benefits and risks of massage; I will consult my massage therapist with any questions or concerns immediately. I have reported all health conditions of which I am aware and will inform my practitioner of any changes in my health.

Signature _____

Printed Name _____ Date _____