McKinnon Body Therapy Center

MEDICAL HISTORY INTAKE FORM

Client Name: _____ Date of Birth: _____

Emergency Contact: _____

Do you have any areas of pain or discomfort? _____

_____

_____

Please mark all of the following which apply to you:

____ contagious skin condition

____ open sores of wounds

____ recent accident or injury

____ current fever or swollen glands

____ cancer

____ diabetes

____ spinal issues

____ pregnant or possibly pregnant

____ asthma

____ joint disorder or artificial joint

____ osteoporosis

____ epilepsy

____ heart condition

____ high or low blood pressure

____ varicose veins

____ allergies

Please list any other medical conditions of note: _____

_____

Please list any medications, herbs, or supplements you are taking: _____

_____

Massage should not be performed under certain medical conditions, and I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree there shall be no liability on the part McKinnon BTC if I fail to do so.

Client Signature: _____ Date: _____