

## Client Intake Form – Therapeutic Massage

Name \_\_\_\_\_ Phone (Day) \_\_\_\_\_ Cell \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Email \_\_\_\_\_ Occupation \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Referred by \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.**

Have you had a professional massage before? Yes No If yes, how often? \_\_\_\_\_

Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain \_\_\_\_\_

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No

If yes, please explain \_\_\_\_\_

Do you have sensitive skin? Yes No

Are you wearing  contact lenses  dentures  a hearing aid  prosthetics?

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe \_\_\_\_\_

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe \_\_\_\_\_

How do you feel the stress in your work, family, or other aspect of your life affected your health?

muscle tension  anxiety  insomnia  irritability  other \_\_\_\_\_

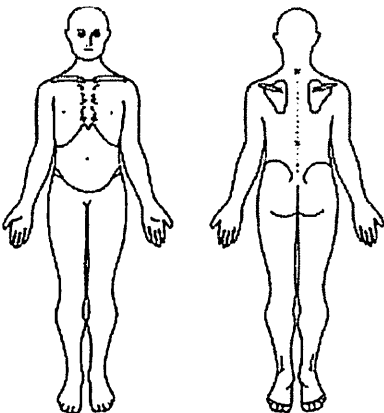
Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort?

Yes No If yes, please identify \_\_\_\_\_

Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain \_\_\_\_\_

Circle any specific areas you would like the massage therapist to concentrate on during the session:



## Medical History

Do you currently or have you ever had any of the following: (please check)

- |   |   |
|---|---|
| <input type="checkbox"/> phlebitis                                      | <input type="checkbox"/> tennis elbow                       |
| <input type="checkbox"/> deep vein thrombosis/blood clots               | <input type="checkbox"/> recent fracture                    |
| <input type="checkbox"/> joint disorder                                 | <input type="checkbox"/> recent surgery                     |
| <input type="checkbox"/> rheumatoid arthritis/osteoarthritis/tendonitis | <input type="checkbox"/> artificial joint                   |
| <input type="checkbox"/> osteoporosis                                   | <input type="checkbox"/> sprains/strains                    |
| <input type="checkbox"/> epilepsy                                       | <input type="checkbox"/> current fever                      |
| <input type="checkbox"/> headaches/migraines                            | <input type="checkbox"/> swollen glands                     |
| <input type="checkbox"/> cancer   | <input type="checkbox"/> allergies/sensitivity              |
| <input type="checkbox"/> diabetes                                       | <input type="checkbox"/> heart condition                    |
| <input type="checkbox"/> decreased sensation                            | <input type="checkbox"/> high or low blood pressure         |
| <input type="checkbox"/> back/neck problems                             | <input type="checkbox"/> circulatory disorder               |
| <input type="checkbox"/> Fibromyalgia                                   | <input type="checkbox"/> varicose veins                     |
| <input type="checkbox"/> TMJ  | <input type="checkbox"/> atherosclerosis                    |
| <input type="checkbox"/> carpal tunnel syndrome                         | <input type="checkbox"/> easy bruising                      |
| <input type="checkbox"/> contagious skin condition                      | <input type="checkbox"/> recent accident or injury          |
| <input type="checkbox"/> open sores or wounds                           | <input type="checkbox"/> pregnancy If yes, how many months? |

Are you currently under medical supervision? Yes No

If yes, please explain \_\_\_\_\_

Do you see a chiropractor? Yes No If yes, how often? \_\_\_\_\_

Are you currently taking any medication? Yes No

If yes, please list \_\_\_\_\_

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Massage Therapist \_\_\_\_\_ Date \_\_\_\_\_