

Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Primary Ph. # _____ Secondary Ph. # _____

Address _____ City/State/Zip _____

Email _____ Date of birth _____ Occupation _____

Referred by _____ May I thank them for referring you? Yes No

The following information will be used to help plan safe and effective massage sessions.

Please answer the questions to the best of your knowledge.

Today's date _____

1. Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? _____

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

If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses () dentures () a hearing aid ()?

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

If yes, please describe _____

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

If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think it has affected your health?

Muscle tension () anxiety () insomnia () irritability () other _____

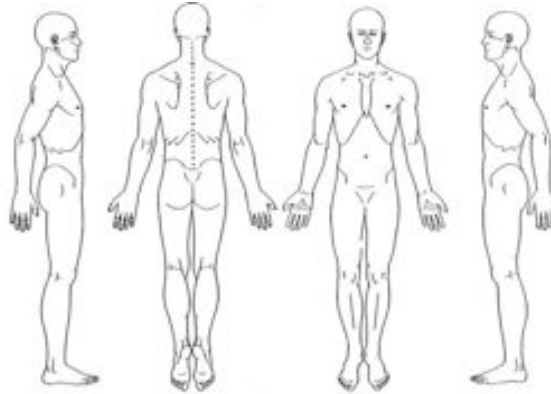
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please identify _____

10. 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

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently taking any medication? Yes No

If yes, please list _____

12. Please check any condition listed below that applies to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> phlebitis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> high or low blood pressure |
| <input type="checkbox"/> deep vein thrombosis/blood clots | <input type="checkbox"/> decreased sensation | <input type="checkbox"/> heart condition |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> artificial joint |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> headaches/migraines | <input type="checkbox"/> sprains/strains | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> TMJ | <input type="checkbox"/> circulatory disorder |
| <input type="checkbox"/> pregnancy if yes, how many months? _____ | | |
| <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis | | |

Please explain any condition that you have marked above _____

13. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session – only the area being worked on will be uncovered.

I, _____ (print name) 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 this 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 my primary care practitioner for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal 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 profiles and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____