Client Intake Form – Therapeutic Massage

Name ______________________________ Phone (Day) ________________ Cell _______________

Address___________________________________ City_________________ State____Zip________

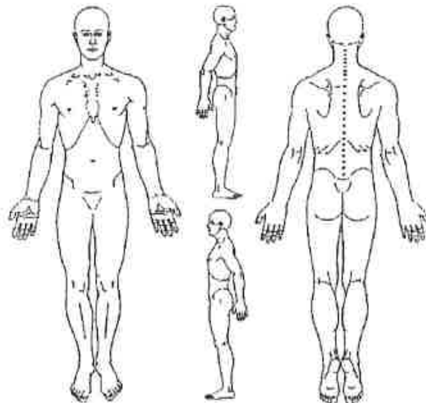
Date of Birth ___/___/____ Referred by ____

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___ Is 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 explain ____*
- ❖ *Do you perform any repetitive movement in your work, sports, or hobby? Yes___ No___*
  - ○ *If yes, please explain____*
- ❖ *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 your session:



MEDICAL HISTORY

Do you currently or have you ever had any of the following? (Please check box)

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

- *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 medications? 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?*___________

  ____

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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 or 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 during 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 _______________