

Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Phone (Day) _____ Phone (Eve) _____

Address _____

City/State/Zip _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____

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

1. Date of initial visit _____

2. Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy? _____

3. Do you have any difficulty lying on your front, back or side? Yes No
If yes, please explain _____

4. Do you have any allergies to oils, lotions or ointments? Yes No
If yes, please explain _____

5. Do you have sensitive skin? Yes No

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

7. Do you sit for long hours at a work station, computer or while driving? Yes No
If yes, please explain _____

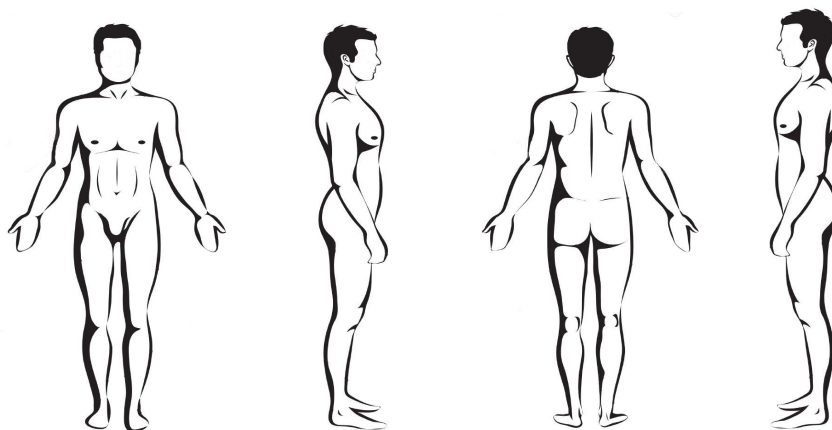
8. Do you perform any repetitive movement in your work, sports or hobby? Yes No
If yes, please explain _____

9. Do you experience stress in your work, family or other aspects of your life? Yes No
If yes, how has it has affected your health? Muscle tension () anxiety () insomnia () irritability ()
other _____

10. Is there an area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please explain _____

11. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____

12. Circle any specific area 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.

13. Are you currently under any medical supervision? Yes No

If yes, please explain_____

14. Do you see a chiropractor? Yes No If yes, how often?_____

15. Are you currently taking any medications? Yes No If yes, please explain_____

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

contagious skin condition

phlebitis

open sores or wounds

deep vein thrombosis/blood clots

easy bruising

joint disorder/rheumatoid arthritis/

recent accident or injury

osteoarthritis/tendonitis

recent fracture

osteoporosis

recent surgery

epilepsy

artificial joint

headaches/migraines

sprains/strains

cancer

current fever

diabetes

swollen glands

decreased sensation

allergies/sensitivity

back/neck problems

heart condition

Fibromyalgia

high or low blood pressure

TMJ

circulatory disorder

carpal tunnel syndrome

varicose veins

tennis elbow

atherosclerosis

pregnancy (If yes, _____ months)

Please explain any that you have marked above_____

17. If 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. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

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 a physician, chiropractor or other qualified medial specialist 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_____

Signature of Massage Therapist_____ Date_____