Client Intake Form – Therapeutic Massage

Personal Information:

Name	Phone (Day)	Phone (Eve)
Address		
City/State/Zip		
email	Date of Birth	Occupation —————
Emergency Contact		Phone
	will be used to help plan safe and effonts on the best of your knowledge.	ective massage sessions.
Date of Initial Visit		
1. Have you had a profession	onal massage before? Yes No	
If yes, how often do	you receive massage therapy?	
2. Do you have any difficult	y lying on your front, back, or side? Yes	No
If yes, please explai	n	
	s to oils, lotions, or ointments? Yes N	lo
4. Do you have sensitive skir	n? Yes No	
5. Are you wearing contact	lenses () dentures () a hearing aid () ?	
,	at a workstation, computer, or driving?	Yes No
	etitive movement in your work, sports, or ho	·
If yes, how do you t	in your work, family, or other aspect of you hink it has affected your health? anxiety () insomnia () irritability () or	
9. Is there a particular area	of the body where you are experiencing t	tension, stiffness, pain
or other discomfort? Yes		
If yes, please identif	<u></u>	
10. Do you have any particu	ular goals in mind for this massage session?	? Yes No
If yes, please explai	n	
Circle any specific areas yo	u would like the	
massage therapist to conce	entrate on	1) (1)
during the session:		
Continued on page 2		LS W W

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 under medical super	rvision? Yes No
12. Do you see a chiropractor? Yes	No If yes, how often?
13. Are you currently taking any medicat	,
If yes, please list	
14. Please check any condition listed bel	
() contagious skin condition	
() open sores or wounds	() phlebitis
	() deep vein thrombosis/blood clots
() easy bruising	() joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
() recent accident or injury	() osteoporosis
() recent fracture	() epilepsy
() recent surgery	() headaches/migraines
() artificial joint	() cancer
() sprains/strains	() diabetes
() current fever	() decreased sensation
() swollen glands	() back/neck problems
() allergies/sensitivity	() Fibromyalgia
() heart condition	() TMJ
() high or low blood pressure	() carpal tunnel syndrome
() circulatory disorder	() tennis elbow
() varicose veins	() pregnancy If yes, how many months?
() atherosclerosis	
Please explain any condition that you ha	ve marked above
15. Is there anything else about your hea	th history that you think would be useful for your massage practitioner to
know to plan a safe and effective ma	issage session for you?
·	
Draping will be used during the session –	only the area being worked on will be uncovered.
	ompanied by a parent or legal guardian during the entire session.
_	ed by parent or legal guardian for any client under the age of 17.
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I	(print name) understand that the massage I receive is provided
	lief of muscular tension. If I experience any pain or discomfort during this
•	upist so that the pressure and/or strokes may be adjusted to my level of
•	e should not be construed as a substitute for medical examination,
	see a physician, chiropractor or other qualified medical specialist for any
	re of. I understand that massage therapists are not qualified to perform
	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 th	erapist 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
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Signature of Massage Therapist	Date