Client Intake Form – Therapeutic Massage

Personal Information:

Name_____Email_____

Address_____

City/State/Zip_____

Cell Phone_____ Date of Birth_____ Occupation_____

Emergency Contact_____ Phone_____

May I contact you by mail? Yes or No Text? Yes or No Email? Yes or 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.

Date of Initial Visit_____

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

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 explain_____

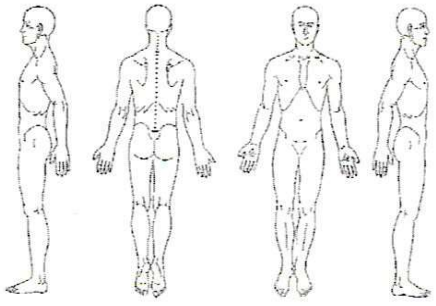
10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain

11. Please circle the level of conversation you would like to have with your massage therapist during your massage.

    No talking – 1 2 3 4 5 6 7 8 9 10 – Full conversation

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



Client Intake Form – Therapeutic Massage

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 supervision? Yes No

If yes please explain_____

12. DO you see a chiropractor or physical therapist Yes No If yes, how often or last appointment date?_____

13. Are you currently taking any medications? Yes No

If yes please explain and list_____

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

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

Please explain any condition that you have marked above_____
_____
_____

15. 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.
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 or muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so 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 medical 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 profile and understand that there shall be no liability on the therapist's part should I fail to do.

Signature of Client _____Date_____

Signature of Massage Therapist _____Date _____