Client Intake Form – Therapeutic Massage

Personal Information:

Name: _____ Phone (Day): _____

Address: _____ Phone (Eve): _____

City: _____ State / Zip: _____

Email: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

(The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.) Initial Visit 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: _____

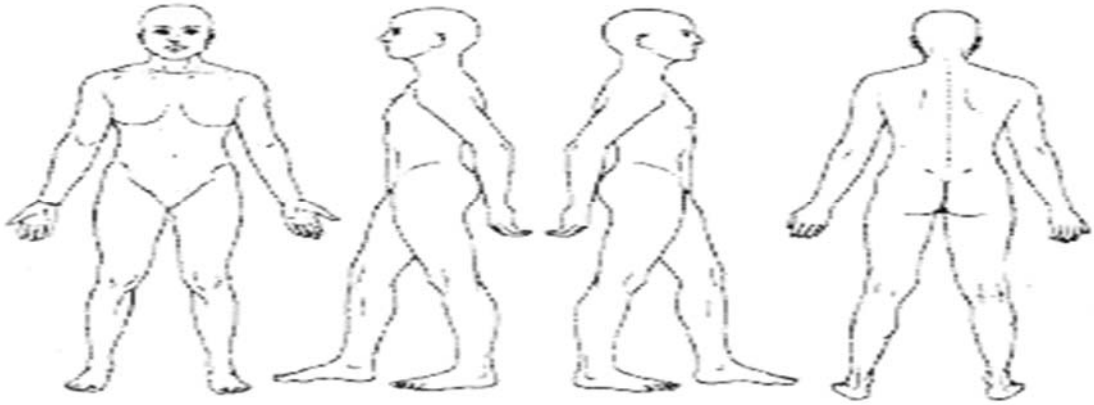
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? **Yes** **No**

   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



Medical History

In order to plan a massage session that is safe and effective, we 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? **Yes** **No**

    If yes, how often? _____

13. Are you currently taking any medication? **Yes** **No**

    If yes, please list _____

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

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

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, _____ 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 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 so.

How do you hear about us? _____

Signature of client _____Date _____

Signature of Massage Therapist _____Date _____