

Massage Client Intake Form



Personal Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ DOB: _____

Date of birth: _____ Emergency Contact: _____

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? Y N If yes, how often? _____

Do you have difficulty lying on your back, front or side? Y N If yes, please explain _____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Y N If yes, please explain _____

Do you have sensitive skin? Y N

Are you wearing: contact lenses dentures hearing aids prosthetics

Do you sit for long hours at a workstation, computer or driving? Y N If yes, please explain _____

Do you perform any repetitive movement in your sport, work or hobby? Y N If yes, please explain _____

Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort? Y N

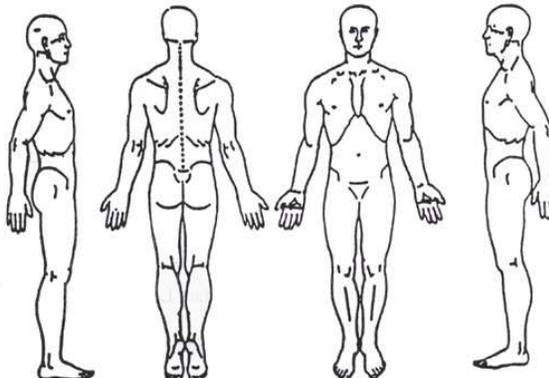
If yes, please explain _____

Do you have any particular goals for this massage session? Y N If yes, please explain _____

Are there any areas you do not want massaged today? _____

Please indicate with an 'X' areas of pain, tension or injury on figures below.

P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling



Massage Client Intake Form Continued



Medical History

Are you currently under medical supervision? Y N If yes, please explain _____

Do you see a chiropractor? Y N If yes, please explain _____

Are you currently taking any medications? Y N If yes, please explain _____

Do you currently or have you ever had any of the following? Please check all that apply

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

Please explain any condition(s) you have marked above: _____

Please list any recent surgeries or injuries within the last 5 years: _____

Information

How did you hear about me? _____ May I send newsletter/promotional emails? Y N

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. Massage should be modified under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions to the best of my knowledge.
3. Late arrivals – sessions may be shortened in order to accommodate appointments that follow. Payment is expected in full regardless of length of treatment given. Please arrive at least ten minutes before your scheduled appointment time in order to ensure a full massage session.
4. You may cancel your appointment, without charge, any time before the close of business on the business day preceding your appointment. Same day cancellations will be charged 50% of the scheduled service price. If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be charged full price for the scheduled service.

Signature: _____ Date: _____