

client intake form

client signature _____

personal information

name _____ date of birth _____

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

work phone _____ ext. _____

email _____

occupation _____

employer _____

employer address _____

marital status _____ if married, spouses name _____

referred by _____

emergency contact name (relationship) _____ emergency contact phone _____

physician's name _____ physician's phone _____

massage experience

Have you had a professional massage before? ☐ Yes ☐ No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)? _____

How long have you been receiving massage therapy? _____

Frequency of massages? _____

What are your goals for treatment? _____

health history

Musculoskeletal

- ___ Bone or joint disease
- ___ Tendonitis/Bursitis
- ___ Arthritis/Gout
- ___ Jaw Pain (TMJ)
- ___ Lupus
- ___ Spinal Problems
- ___ Migraines/Headaches
- ___ Osteoporosis

Circulatory

- ___ Heart Condition
- ___ Phlebitis/Varicose Veins
- ___ Blood Clots
- ___ High/Low Blood Pressure
- ___ Lymphedema
- ___ Thrombosis/Embolism

Respiratory

- ___ Breathing Difficulty/Asthma
- ___ Emphysema
- ___ Allergies, specify: _____
- ___ Sinus Problems

Nervous System

- ___ Shingles
- ___ Numbness/Tingling
- ___ Pinched Nerve
- ___ Chronic Pain
- ___ Paralysis
- ___ Multiple Sclerosis
- ___ Parkinson's Disease

Reproductive

- ___ Pregnant, stage _____
- ___ Ovarian/Menstrual Problems

date of initial visit _____

current health

Reason for initial visit _____

Height & weight _____

Do you exercise regularly and/or participate in any sports? ☐ Y ☐ N

If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? ☐ Y ☐ N

If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? ☐ Y ☐ N

If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? ☐ Y ☐ N

If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? ☐ Y ☐ N

If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? ☐ Y ☐ N

If yes, describe _____

Do you have sensitive skin? ☐ Y ☐ N

Do you have any allergies to oils, lotions or ointments? ☐ Y ☐ N

If yes, please explain _____

List any medications you are currently taking _____

List any known allergies _____

Skin

___ Allergies, specify: _____

- ___ Rashes
- ___ Cosmetic Surgery
- ___ Athlete's Foot
- ___ Herpes/Cold Sores

Digestive

- ___ Irritable Bowel Syndrome
- ___ Bladder/Kidney Ailment
- ___ Colitis
- ___ Crohn's Disease
- ___ Ulcers

Psychological

- ___ Anxiety/Stress Syndrome
- ___ Depression

Other

- ___ Cancer/Tumors
- ___ Diabetes
- ___ Drug/Alcohol/Tobacco Use
- ___ Contact Lenses
- ___ Dentures
- ___ Hearing Aids

Any other medical condition(s) not listed: _____

Please explain any of the conditions that you have marked above: _____

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by, _____, (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

I have received a copy of the therapist's policies, I understand them and agree to abide by them.

Client Signature

Date