



Client Intake Form – Therapeutic Massage

Name	Phone	Date of Birth
Address		
Email:		
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.

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

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

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

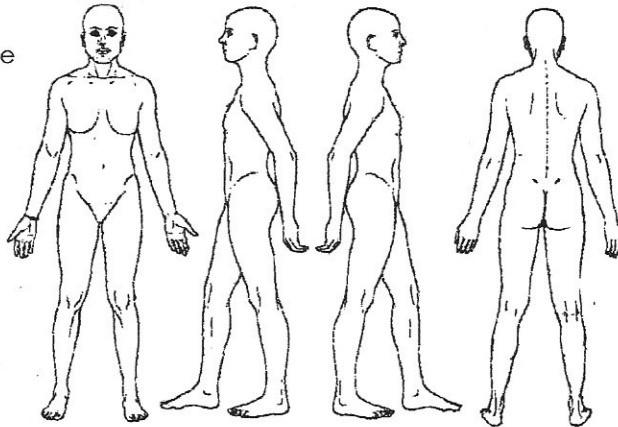
If yes, please explain _____

5. Are you wearing contact lenses ()

dentures () a hearing aid () ?

If yes, how do you think it has

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



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? 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:

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

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? _____