Massage Therapy - Client Intake Form

Name: ____ Phone: ____________________________

Address: ____

City: ______________________ State: _______ Zip: __________ Email: ________________________

DOB: ___________________ Occupation: ____

Emergency Contact Name and Phone: ____

Name and number of Health Care Provider: ____

Allergies (including Nuts/Fruits/Oils/Lotions): ____

Do you have sensitive Skin? □ Yes □ No   Do you have difficulty lying on: □ front □ back □ side □ none

Do you sit long hours? □ Yes □ No Any repetitive movements? ________________________________

Hobbies? __________________________________ Sports? ________________________________

Are you taking any medications? (name and reason): ____

____

Do you wear: □ contact lenses □ dentures □ hearing aids □ prosthetics □ implanted devices □ hairpiece

Do you have pain? □ Yes □ No How much on scale of 0-10? ____ Where in your body? _______________

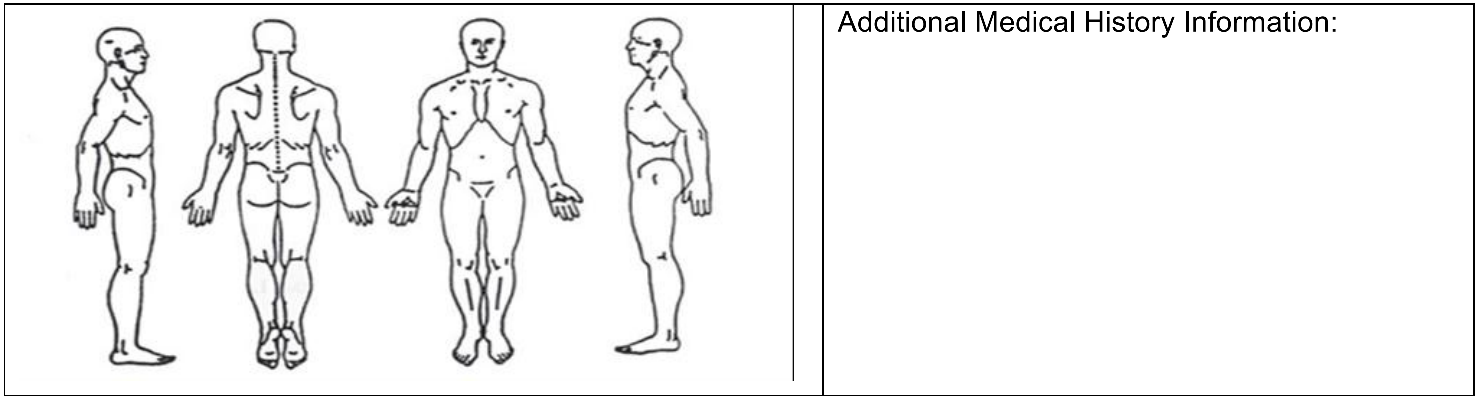
Any injuries or surgeries in the past? ____

Please mark “X” for current conditions and “P” for past conditions:

____ Amputations
____ Arthritis
____ Artificial Joint
____ Asthma / Emphysema
____ Autoimmune Condition
____ Back Pain
____ Blood Clots/Thrombosis
____ Cancer
____ Carpal Tunnel Syndrome
____ Chronic Pain
____ Circulatory Disorder
____ Cold / Flu
____ Depression / Anxiety
____ Diabetes
____ Easy Bruising
____ Epilepsy / Seizures
____ Fibromyalgia
____ Fractures
____ Headaches / Migraines

____ Heart Condition
____ Hepatitis
____ High Blood Pressure
____ Insomnia
____ Lymphedema / Swollen Glands
____ Multiple Sclerosis
____ Muscle Sprain / Strain
____ Osteoporosis
____ Parkinson’s Disease
____ Pregnancy
____ Shingles / Herpes
____ Skin Disorders
____ Stroke
____ Tennis Elbow
____ TMJ
____ Varicose Veins
____ Whiplash
____ Wounds / Open Sores
____ Other______________________

Mark any areas of concern:



Additional Medical History Information:

Have you had professional massages before? □ Yes □ No What type?______________________________

What is your primary concern today? ____

What are your goals for massage sessions? ____

What type of pressure do you prefer? □ Light □ Medium □ Firm □ Specifics: _______________________

Any areas you don't want to get worked on? □ Feet □ Glutes □ Abdomen □ Pectoralis □ Face □ Scalp

Any of the following may occur during a massage therapy session and are normal responses to relaxation. Trust your body to express what it needs to:
1. Urge to move or change position 2. Sighing, yawning, stomach gurgling 3. Memories, emotional feelings and/or expressions 4. Movement of intestinal gas 5. Energy shifts, falling asleep.

Consent for Treatment

It is my choice to receive massage therapy. I understand that massage/bodywork 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 physical or mental ailment of which I am aware. I understand that massage/bodywork practitioners 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 and bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
I understand that draping will be used during the session and only the area being worked on will be uncovered. I also understand that any illicit or sexually suggestive remarks or advances made by me will constitute sexual harassment and will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.
Understanding all of this, I give my consent to receive care.

Client Signature: ____ Date: _________________

Therapist Notes: