Massage Therapy Client Intake Form

Personal Information

Date of Initial Visit _____ Referred By _____ DOB _____

First Name _____ Last Name _____

Address _____ City/State/Zip _____

Cell Phone _____ Home Phone _____

Email _____

Occupation _____ Employer _____

Employer Address _____

Marital Status _____ Spouse's Name _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone Number _____

Primary Physician's Name _____ Phone _____

Massage Experience

Have you had a professional massage? Y N

If yes, what types of massage have you had? _____

How long have you been receiving massage therapy? _____

How frequently do you receive massage therapy? _____

What are your goals for treatment? _____

Current Health

Reason for initial visit _____

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

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

If yes, please describe _____

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

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

If yes, please describe _____

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

If yes, please describe _____

Do you have sensitive skin? Y N

If yes, please explain _____

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

List any medications you are currently taking _____

_____

List any known allergies _____

_____

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 _____

Nervous System

- ◯ Shingles
- ◯ Numbness/tingling
- ◯ Pinched nerve
- ◯ Chronic pain
- ◯ Paralysis
- ◯ Multiple sclerosis
- ◯ Parkinson's disease

Reproductive

- ◯ Pregnant, stage _____
- ◯ Ovarian/menstrual problems
- ◯ Prostate

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 conditions not listed

_____

Please explain any of the conditions that you have marked above

_____

Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

_____ _____

Signature Date