

CLIENT INTAKE FORM – THERAPEUTIC MASSAGE

Referred by: Friend ___ Family ___ Other ___ Referral Person’s Name: _____

(the above information might apply to any coupons or specials we have)

Personal Information:

Name: (First) _____ (MI) _____ (Last) _____

Phone (Day) _____ Phone (Eve) _____

Address: _____

City/State/Zip _____

Email _____ Date of Birth _____ Occupation _____

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

5. Are you wearing contact lenses () denture () a hearing aid () ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please explain _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please explain _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

If yes, how do you think it has 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

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If yes, please
identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

If yes, please
explain _____

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 |

