client intake form

client signature

date of initial visit

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
- ___ Prostate

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 :