Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ 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 ( ) dentures ( ) a hearing aid ( ) ?

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

　　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
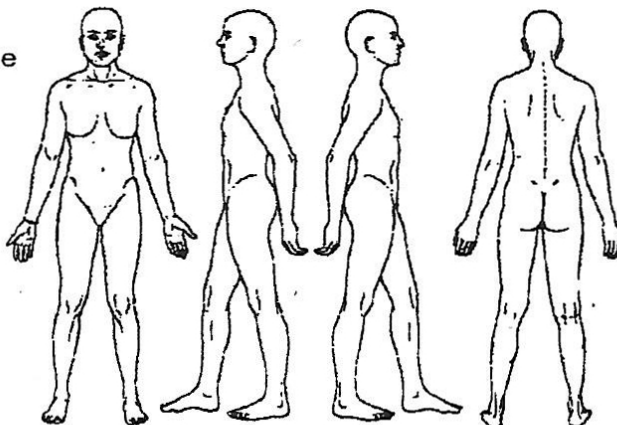
　or other discomfort? Yes No

　　If yes, please identify _____

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

　　If yes, please explain _____

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:

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

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided
for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this
session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of
comfort. I further understand that massage 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
mental or physical ailment that I am aware of. I understand that massage therapists 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 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 therapist updated as to any changes in my medical profile and
understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____