

Client Intake Form – Therapeutic Massage

Name _____ Phone (Day) _____ Cell _____
Address _____ City/State/Zip _____
Email _____ Occupation _____
Date of Birth _____ Referred by _____
Emergency Contact _____ Phone _____

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? Yes No If yes, how often? _____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No

If yes, please explain _____

Do you have sensitive skin? Yes No

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

If yes, please describe _____

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

If yes, please describe _____

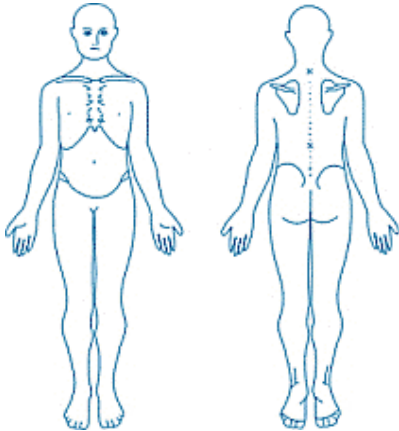
Do you have any injuries or have you had any surgeries in the past? Yes No

If yes, please describe _____

Are there any areas of the body you do not want addressed? Yes No

If yes, please explain _____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

Do you currently or have you ever had any of the following: (please check)

phlebitis
deep vein thrombosis/blood clots
joint disorder
rheumatoid arthritis/osteoarthritis/tendonitis
osteoporosis
epilepsy
headaches/migraines
cancer
diabetes
decreased sensation
back/neck problems
Fibromyalgia
TMJ
carpal tunnel syndrome
contagious skin condition
open sores or wounds

tennis elbow
recent fracture
recent surgery
artificial joint
sprains/strains
current fever
swollen glands
allergies/sensitivity
heart condition
high or low blood pressure
circulatory disorder
varicose veins
atherosclerosis
easy bruising
recent accident or injury
pregnancy If yes, how many months? _____

Are you currently under medical supervision? Yes No

If yes, please explain _____

Do you see a chiropractor? Yes No If yes, how often? _____

Are you currently taking any medication? Yes No

If yes, please list _____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

I 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 my 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 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 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.

Please give the therapist a 24 hour notice in the event of a cancelled or rescheduled appointment. There will be a charge of \$35.00 if this allotted time is not given.

Signature of client _____ Date _____