Client Intake Form

Name:

Address:

City **State** **Zip**

Best Contact Phone# **Email**

Emergency Contact **Phone**

Birth Date **Referred By**

Physician's Name **Physician's Phone**

Massage Experience

1. **Have you had a professional massage before?_____** **Yes ☐ No ☐**

2. **What type of massage/bodywork have you had? _____**

3. **How long has it been since your last massage therapy _____**

What are your goals for treatment? _____

Information that will be used to help plan safe and effective massage sessions.

4. **Do you have any difficulty lying on your front, back, or side?** **Yes ☐ No ☐**
   If yes, please describe _____
5. **Do you have any allergies to oils, lotions, or ointments?** **Yes ☐ No ☐**
   If yes, please explain _____
6. **Do you sit for long hours at a workstation, computer of driving?** **Yes ☐ No ☐**
   If yes, please describe _____
7. **Do you exercise regularly and/or participate in any sports?** **Yes ☐ No ☐**
   If yes, which sport? _____
8. **Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?** **Yes ☐ No ☐**
   If yes, please identify _____
9. **Have you recently suffered an injury?** **Yes ☐ No ☐**
   If yes, describe: _____
10. **Are you currently under the care of a physician?** **Yes ☐ No ☐**
    If yes, explain _____
11. **Have you had recent surgery?** **Yes ☐ No ☐**
    If yes, explain _____
12. **Do you see a chiropractor?** **Yes ☐ No ☐**
    If yes, how often? _____
13. **Are you currently taking any Medications?** **Yes ☐ No ☐**
    If yes, please list _____
14. **Are you pregnant?** **Yes ☐ No ☐**
    If yes, how many months _____
15. **Have you had any injuries to the tailbone?** **Yes ☐ No ☐**
    If yes, please explain when and how _____

Please check any condition listed below that applies to you:

☐ Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis	☐ Open sores or wounds	☐ Easy bruising
☐ Artificial joint	☐ Recent fracture	☐ Recent surgery
☐ Heart condition	☐ Sprains/strains	☐ Current fever
☐ High or low blood pressure	☐ Allergies/sensitivity	☐ Atherosclerosis
☐ Circulatory disorder	☐ Swollen glands	☐ Varicose veins
☐ Contagious skin condition	☐ Epilepsy	☐ Osteoporosis
☐ Deep vein thrombosis/blood clots	☐ Headaches/migraines	☐ TMJ
☐ Recent accident or injury	☐ Diabetes	☐ Decreased sensation
☐ Back/neck problems	☐ Fibromyalgia	☐ Tennis elbow
☐ Carpal tunnel syndrome	☐ Cancer	☐ Other

16. **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** _____