Client Intake Form - Therapeutic Massage

Client Information

Name _____ Email _____

Phone (cell/day) _____ DOB _____ Age: _____

Address _____ City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Occupation _____ Referred by: _____

Health Information

Are you taking any medications? ☐ yes ☐ no If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no If yes, please list: _____

Are you pregnant? ☐ yes ☐ no If yes, how many months: _____ Due date: _____

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☐ no

If yes, please describe: _____

Areas of swelling	yes no	Diabetes	yes no	Osteoporosis	yes no
Autoimmune disorder	yes no	Fibromyalgia	yes no	Phlebitis	yes no
Back / neck problems	yes no	Headaches	yes no	Sciatica	yes no
Bleeding disorders	yes no	Heart condition	yes no	Seizures	yes no
Blood clots	yes no	Hypertension	yes no	Stroke	yes no
Bruise easily	yes no	Kidney disease	yes no	Tendinitis	yes no
Bursitis	yes no	Multiple sclerosis	yes no	TMJ disorder	yes no
Cancer	yes no	Neurological condition	yes no	Varicose veins	yes no
Contagious condition	yes no	Neuropathy	yes no	Vertigo / dizziness	yes no
Decreased sensation	yes no	Osteoarthritis	yes no		

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? _____

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: _____

Please describe any other injuries or health conditions: _____

Massage Information

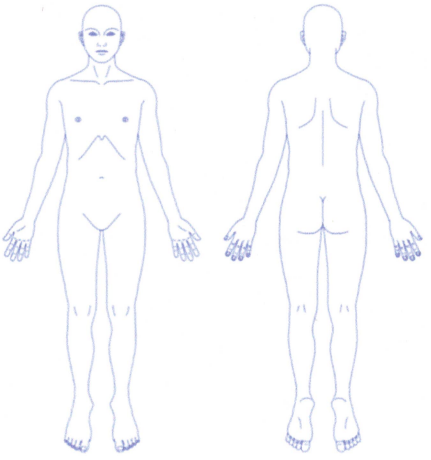
Have you had professional massage before? ☐ yes ☐ no How recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem

_____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of discomfort



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature _____ Date _____

Therapist Signature _____ Date _____