



Therapeutic Massage Client Intake Form

Personal Information

Name _____ email _____

Phone (Cell) _____ Phone (Home) _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

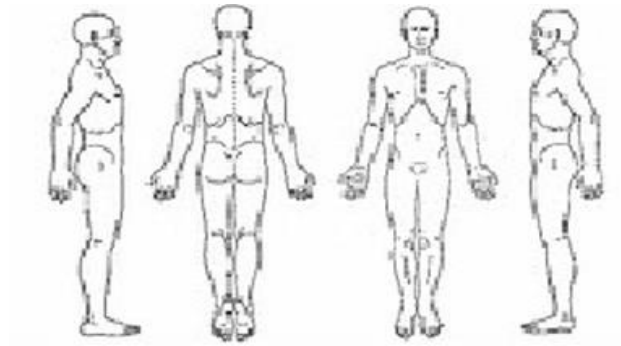
The following information will be used to help plan safe and effective massage sessions.

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 _____

Client Name: _____



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:

- | | |
|---|---|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tenosynovitis |
| <input type="checkbox"/> recent accident of injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> cancer |
| <input type="checkbox"/> current fever | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> atherosclerosis | <input type="checkbox"/> pregnancy if yes, how many months? |

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.

Informed written consent must be provided by parent or legal guardian for any client under the age 17.

Client Name: _____

Consent for Massage Therapy

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 massage 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 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. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapy reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

Consent for minors is required prior to treatment

Signature of Guardian _____ Date _____

Printed name of Guardian _____

Phone number of the Guardian in case of emergency _____

Signature of Massage Therapist _____ Date _____