Client Intake Form

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell Phone _____

Height: _____ Weight: _____ Birth Date: _____

Profession _____

Referred by _____

Physician's Name _____ Physician's Phone _____

Massage Experience

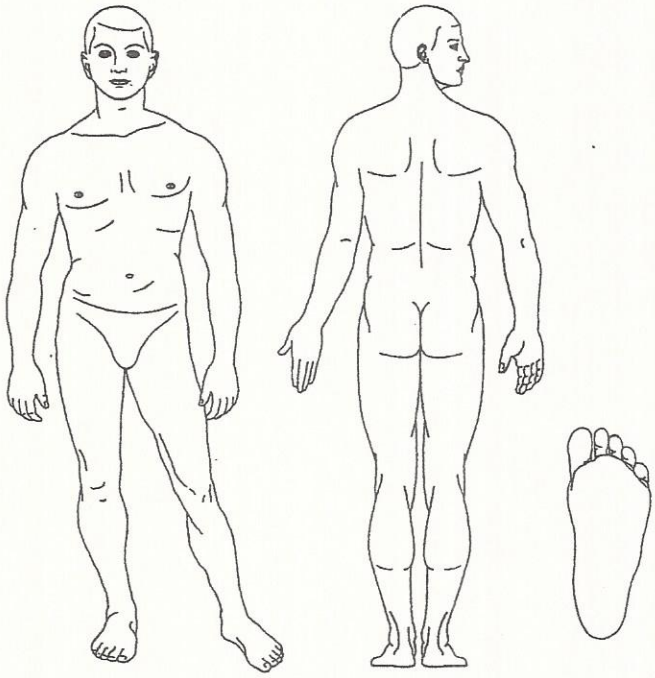
1. Have you had a professional massage before? ..... ❑ Yes ❑ No
2. What types of massage/bodywork have you had? _____
3. How long have you been receiving massage therapy? _____
4. Frequency of treatments? _____
5. What are your goals for treatment? _____

Current Health

6. Do you exercise regularly and/or participate in any sports? ..... ❑ Yes ❑ No
   If yes, which sports? _____
7. Have you recently suffered an injury? ..... ❑ Yes ❑ No
   If yes, describe: _____
8. Have you had any areas of inflammation? ..... ❑ Yes ❑ No
   If yes, describe: _____
9. Are you currently under the care of a physician? ..... ❑ Yes ❑ No
   If yes, explain: _____
10. Have you had recent surgery? ..... ❑ Yes ❑ No
    If yes, explain: _____
11. Medications/Allergies: _____

Health History (check one box per item)

	Yes/Current	Past	No
Contact lenses	☐	☐	☐
Dentures	☐	☐	☐
Back pain/Sciatica	☐	☐	☐
Spinal problems	☐	☐	☐
Osteoporosis	☐	☐	☐
Broken bones	☐	☐	☐
Easy bruising	☐	☐	☐
Skin problems	☐	☐	☐
Allergies	☐	☐	☐
Varicose veins	☐	☐	☐
Phlebitis/Blood clots	☐	☐	☐
Heart problems	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Ulcer	☐	☐	☐
Tendonitis, bursitis, etc.	☐	☐	☐
Arthritis or joint disease	☐	☐	☐
Diabetes	☐	☐	☐
Seizures/Convulsions	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Nerve degeneration	☐	☐	☐
Cancer or tumors	☐	☐	☐
Infectious diseases	☐	☐	☐



Any other medical condition(s) the therapist should be aware of? _____

_____

_____

_____

_____

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 _____