Client Intake Form - Therapeutic Massage

Personal Information:

Name _____Phone _____Mobile _____

Address _____

City/State/Zip _____

Email _____Birthdate _____Occupation_____

Emergency Contact Name & 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_____

Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy?_____

Do you have any difficulty lying on your front, back or side? Yes No

If yes, please explain_____

Do you have any allergies or sensitivities to oils, creams, lotions or essential oils? Yes No

If yes, please explain_____

Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes No

If yes, please explain_____

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

If yes, please describe_____

Are you concerned with any of the following:

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other_____

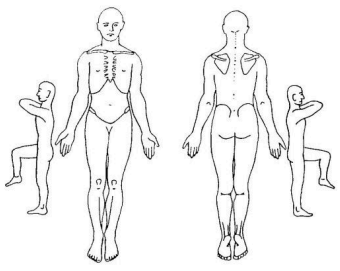
Is there a particular area of your body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please eplain_____

_____

_____

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



Please see reverse side >
Medical History:

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_____

Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) 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
( ) 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
( ) tennis elbow
( ) pregnancy If yes, how many months? _____

Please explain any condition that you have marked above_____

_____

_____

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_____

Signature of Massage Therapist_____ Date_____