

Client Intake Form

Personal Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Email _____

Occupation _____

Referred by _____

Emergency Contact Name _____ Phone Number _____

Massage Experience

Have you had a professional massage before? Yes No
Frequency of massages? _____

What are your goals/ expected outcomes for receiving
massage? _____

Areas of specific tension: _____

Current Health

Do you exercise regularly and/or participate in any sports? Y N

Do you perform any repetitive movement in your
work, sports or hobby? Y N

Do you sit for long hours at a workstation, computer
or driving? Y N

Do you experience stress in your work, family, or other
aspect of your life? Y N

Are you experiencing tension, stiffness, discomfort or pain? Y N

Have you recently had an injury, surgery, or areas of
inflammation? Y N

Do you have sensitive skin? Y N

Do you have any allergies to oils, lotions or ointments? Y N

List any medications you are currently taking _____

Health History (Please check all that apply to you.)

Musculoskeletal

- Bone or joint disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches

Nervous System

- Pinched Nerve
- Shingles
- Numbness/Tingling
- Chronic Pain
- Paralysis
- Multiple Sclerosis
- Parkinson's Disease

Psychological

- Anxiety/Stress Syndrome
- Depression

Circulatory

- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

Reproductive

- Pregnant, stage _____
- Ovarian/Menstrual Problems
- Prostate

Digestive

- Irritable Bowel Syndrome
- Bladder/Kidney Ailment
- Colitis
- Crohn's Disease
- Ulcers

Respiratory

- Breathing Difficulty/Asthma
- Emphysema
- Sinus Problems
- Allergies, specify: _____

Skin

- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold Sores
- Allergies, specify: _____

Other

- Cancer/Tumors
- Diabetes
- Contact Lenses, Hearing Aids, Dentures
- Any other medical condition not listed: _____

Comments: _____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status

-Please understand that there is a \$25 fee for no show appointments.

Kindly give us 12 hours of notice if you need to cancel. INITIAL: _____

Signature _____

Date _____

Consent to Treatment of Minor:

Signature of parent or guardian _____

Date _____