Client Intake Form – Therapeutic Massage

Name______________________________ Phone (Day)________________ Cell________________

Address____________________________________ City/State/Zip____________________________

Date of Birth________________ Referred by____

Emergency Contact____ Phone_____________________

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? Yes No If yes, how often?___________________________

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

If yes, please explain____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No

If yes, please explain____

Do you have sensitive skin? Yes No

Are you wearing □ contact lenses □ dentures □ a hearing aid □ prosthetics?

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe____

When dealing with stress from work, family, or other aspects of life, how does it affect you?

□ muscle tension □ anxiety □ insomnia □ irritability □ headaches □ other__________________________

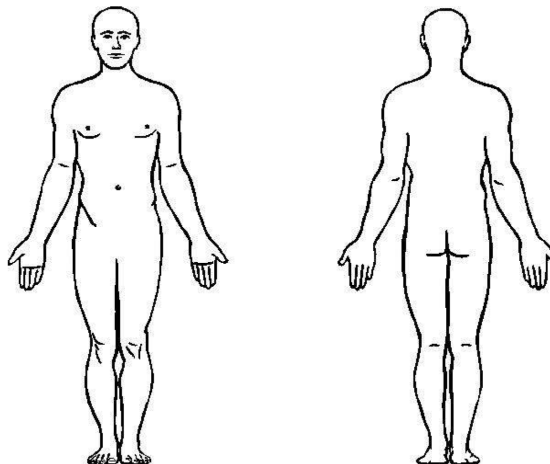
Is there a specific area of the body where you are experiencing tension, stiffness, pain, or discomfort?

Yes No If yes, please identify____

Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain____

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



Medical History

Do you currently or have you ever had any of the following: (please check)

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

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____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you?____
____

I 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 my session, I will immediately inform the therapist so that the pressure and/or stroke may be adjusted to my level of comfort. I further understand that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapist are not qualified to perform 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

____

Responsible Party (If under 18) Signature Date

____

LMT Date