

# MASSAGE ITHACA

## CLIENT INTAKE FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_  
Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

**\*\*Please answer the questions below.**

How did you hear about me? \_\_\_\_\_

Have you received massage therapy or bodywork before? ☐ Yes ☐ No

Date of last Massage: \_\_\_\_\_ Therapist Seen: \_\_\_\_\_

Chiropractor? \_\_\_\_\_ Physical Therapist? \_\_\_\_\_

Acupuncturist? \_\_\_\_\_ Areas to avoid? \_\_\_\_\_

Medications, Vitamins, or herbs? ☐ Yes ☐ No If yes, which ones \_\_\_\_\_

**\*\*Please mark any of the following conditions you may currently have.**

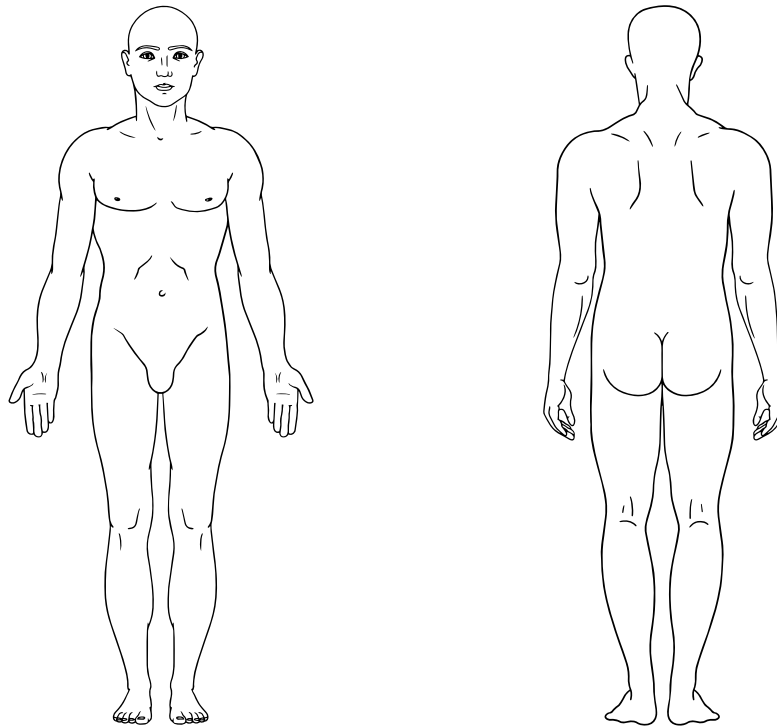
- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Recent injury        | <input type="checkbox"/> Bruise easily           | <input type="checkbox"/> Recent surgery               |
| <input type="checkbox"/> Infection            | <input type="checkbox"/> Old Injuries            | <input type="checkbox"/> Open wounds                  |
| <input type="checkbox"/> Skin condition       | <input type="checkbox"/> Whiplash                | <input type="checkbox"/> Circulation issues           |
| <input type="checkbox"/> Head, neck, ear pain | <input type="checkbox"/> Fibromyalgia            | <input type="checkbox"/> Chronic/acute pains          |
| <input type="checkbox"/> Sinus congestion     | <input type="checkbox"/> Blood clots             | <input type="checkbox"/> Cancer                       |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Varicose veins          | <input type="checkbox"/> Numbness/tingling            |
| <input type="checkbox"/> TMJd                 | <input type="checkbox"/> Heart condition         | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Arthritis/tendonitis | <input type="checkbox"/> Bell's Palsy            |   |

**\*\*Do you have any acute (within the last 3 days) injuries or illnesses?** ☐ Yes ☐ No \_\_\_\_\_

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose diseases, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination; rather, it is a form of health and wellness utilizing various techniques and modalities. I take responsibility for alerting my therapist to any physical, mental or emotional changes that could affect this work.

Signature \_\_\_\_\_ Date \_\_\_\_\_

On the body diagram below, please shade, X, or circle the areas of feeling pain or tension in your body right now:



Circle the number below to indicate your present level of PAIN:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)    Is the pain always present?   YES / NO

What makes it feel BETTER? \_\_\_\_\_

What makes it feel WORSE? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Circle your job requirements:      Heavy Labor   Light Labor   Mainly Sitting   Mainly Standing

Can you perform your daily activities?      Yes, all activities.   Only some.   Not at all.

**-----DO NOT FILL BELOW THIS LINE -----Therapist Notes:**

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Why does the client think these areas have tension?

How do they think that affects the rest of their body?

Stress reduction techniques:

Recommendations:

Recommended for next appointment: