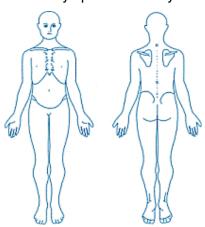
Client Intake Form – Therapeutic Massage

Name	Phone (Day)	Cell	
Address	City/State/Zip		
Email	Occupation		
Date of Birth	Referred by		
Emergency Contact		Phone	
	ation will be used to help your the ver the questions to the best of yo	rapist plan a safe and effective massage our knowledge.	
Have you had a profes	sional massage before? Yes No	If yes, how often?	
Do you have any difficulty lying on your front, back, or side? Yes No			
If yes, please e	xplain		
Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No			
If yes, please e	xplain		
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			
Do you perform any repetitive movement in your work, sports, or hobby? Yes No			
If yes, please describe			
How do you feel the stress in your work, family, or other aspect of your life affected your health?			
□ muscle tensi	on 🗆 anxiety 🗆 insomnia	□ irritability □ 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	ne 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? Ye	
If yes, please explain	
Do you see a chiropractor? Yes No If yes, how	
Are you currently taking any medication? Yes N	No
If yes, please list	
Is there anything else about your health history that	at you think would be useful for your massage therapist to
know to plan a safe and effective massage session	n for you?
therapist so that the pressure and/or strokes may be that massage should not be construed as a substite that I should see a physician other qualified medical aware of. I understand that massage therapists are prescribe, or treat any physical or mental illness, as should be construed as such. Because massage so I affirm that I have stated all my known medical construed as such.	mfort during my session, I will immediately inform the be adjusted to my level of comfort. I further understand that for medical examination, diagnosis, or treatment and all specialist for any mental or physical ailment that I am e not qualified to perform adjustments, diagnose, and that nothing said in the course of the session given hould not be performed under certain medical conditions and answered all questions honestly. I agree to my medical profile and understand that there shall be no
Signature of client	Date
	_
Signature of Massage Therapist	Date