



CLIENT INTAKE FORM - THERAPEUTIC MASSAGE

Name _____ Phone _____

Address _____

Occupation _____ Date of Birth _____

Email Address _____

LIFESTYLE INFORMATION

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: _____

1. Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back or side? Yes No
If yes, please explain _____

3. Do you have any allergies to lotions, oils or ointments? Yes No
If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses () Dentures () hearing aid () ?

6. Do you sit for long hours at a workstation, computer or driving? Yes No
If yes, please describe _____

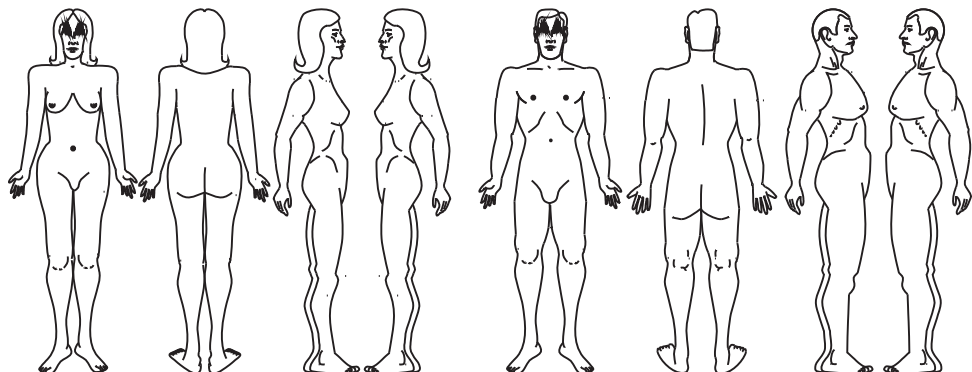
7. Do you perform any repetitive movement in your work, sports or hobby? Yes No
If yes, please describe _____

8. Do you experience stress in your work, family or other aspect of your life? Yes No
If yes, how do you think it has affected your health?
muscle tension () anxiety () insomnia () irritability () other _____

9. Is there an area of your body where you are experiencing tension, stiffness pain or other discomfort?
Yes No If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____

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



MEDICAL INFORMATION

In order to plan a massage session that is safe and effective I need some general information about your medical history

11. Are you currently under medical supervision? Yes No

If yes, please explain _____

12. Do you see a chiropractor? Yes No If yes, how often? _____

13. Are you currently taking any medications? Yes No

If yes, please list _____

14. Please check any condition listed below that applies to you:

() Have you ever had or currently have the Coronavirus (Covid-19)

- | | |
|---|--|
| () contagious skin condition | () phlebitis (inflammation of the veins) |
| () open sores or wounds | () deep vein thrombosis/blood clots |
| () easy bruising | () joint disorder/rheumatoid arthritis/osteoarthritis |
| () recent accident or injury | () tendonitis |
| () recent fracture | () osteoporosis (brittle bones) |
| () recent surgery | () epilepsy |
| () artificial joint | () headaches/migraines |
| () sprains/strains | () cancer |
| () current fever | () diabetes |
| () swollen glands | () decreased sensation |
| () allergies/sensitivity | () back/neck problems |
| () heart condition | () fibromyalgia (sore/painful connective tissue) |
| () high or low blood pressure | () TMJ (temporomandibular joint) |
| () circulatory disorder | () carpal tunnel syndrome |
| () varicose veins | () tennis elbow |
| () atherosclerosis (fatty deposits arterial walls) | () pregnancy (if yes, how many months? ____) |

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for the massage practitioner to know how 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 16 years of age must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or guardian for any client under the age of 16.

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 and physical ailment that I am aware of. I understand that massage therapists are not qualified to diagnose, prescribe or treat any physical and 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 therapists part should I fail to do so.

Signature of Client _____

Date _____