

Client Intake Form

Personal Information

name _____ date of birth _____

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

work phone _____ ext. _____

email _____

☐ Please email me with any promotions and discounts.

emergency contact name (relationship) emergency contact phone _____

How did you discover us? _____

Massage Experience

Have you had a professional massage before? ☐ Yes ☐ No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)? _____

How long have you been receiving massage therapy? _____

Frequency of massages? _____

Health History

Check all that apply.

MUSCULOSKELETAL

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

RESPIRATORY

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

CIRCULATORY

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

NERVOUS SYSTEM

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

Current Health

Reason for initial visit: _____

Height & weight: _____

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

☐ Yes ☐ No If yes, what kind of exercise/sports?

Do you perform any repetitive movement in your work, sports or hobby? If yes, describe: ☐ Yes ☐ No

Are you experiencing any pain? ☐ Yes ☐ No

If yes, describe: _____

Have you recently had any surgeries? ☐ Yes ☐ No

If yes, describe: _____

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

☐ Yes ☐ No If yes, please explain: _____

REPRODUCTIVE

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

SKIN

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

PSYCHOLOGICAL

- ☐ Anxiety/Stress Syndrome
- ☐ Depression

DIGESTIVE

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

OTHER

- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Drug/Alcohol/Tobacco Use
- ☐ Contact Lenses
- ☐ Dentures
- ☐ Hearing Aids

Please explain any of the conditions that you have marked above: _____

Any other medical condition(s) not listed: _____

List any medications you are currently taking: _____

Are you comfortable with having therapeutic massage on the following areas:

Gluteal Region ☐ Yes ☐ No Pectoral Muscles ☐ Yes ☐ No Abdomen ☐ Yes ☐ No
 Scalp ☐ Yes ☐ No Face ☐ Yes ☐ No Feet ☐ Yes ☐ No

Are there any areas you would like the therapist to avoid? _____

Not So Fine Print

Scope of massage, bodywork, and treatment:

Please read and initial below:

- _____ I understand that the massage/bodywork 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 practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.
- _____ I understand that massage or bodywork 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 or physical ailment of which I am aware.
- _____ I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal 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/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
- _____ Information has been provided to me either verbally or in written form about my services I'll be receiving and I understand the potential effects and aftercare recommendations.
- _____ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment.
- _____ I understand that if I arrive late, my session will end at the originally scheduled time to avoid schedule conflicts.

I verify that all information is correct and current to the best of my knowledge. I understand that any information provided is for safety purposes and will be kept strictly confidential, I hereby give my consent to receive massage services and/or other bodywork or treatment.

Client or Legal Guardian Signature

Date

Practitioner

Date