Client Intake Form – Therapeutic Massage

Personal Information: **Date** _____/_____/_____

Name_____Phone (Day)_____Phone (Eve) _____

Address _____

City/State/Zip _____

email_____Date of Birth_____Occupation _____

Emergency Contact_____Phone _____

Referred by _____

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

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 oils, lotions, or ointments? Yes No

   If yes, please explain _____

4. Do you have sensitive skin? Yes No

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

6. Do you sit for long hours at a workstation, computer, work 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. Are you currently under medical supervision, or a chiropractor Yes No

   If yes, please explain _____

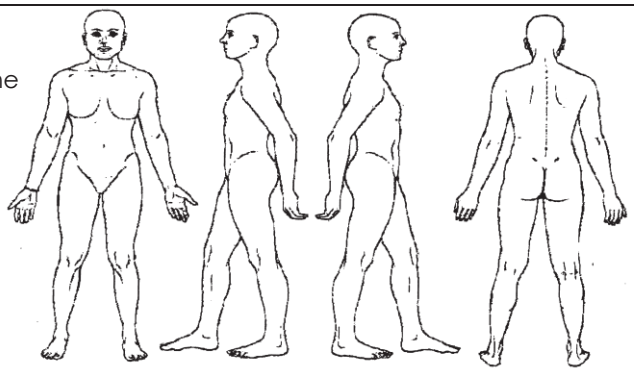
10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain _____

11. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes/No

    If yes, please identify _____

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



Front Left Right Back

Use pain codes to describe any pains
After code use # 1-10 to rate the pain level

PAIN CODES
CP=constant pain
DP=deep pain
EP=excessive activity
IP=intermittent pain
PM=pain in movement
RAD=radiating pain
RP=recurring pain
SP=sharp pain
SPA=spasmodic pain
TP=throbbing pain
TRA=trauma pain
TT=painful to touch

Please complete page 2

Medical History

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

12. Are you currently taking any herb, coffee, alcohol, nicotine, supplements? Yes I _____

If yes, please list _____

13. Please check any condition listed below that applies to you and show all medication or treatment:

CHK	CONDITION	HOW TREATED / MEDICATION	CHK	CONDITION	HOW TREATED / MEDICATION
	POOR BLOOD CIRCULATION / CLOTS			CONTAGIOUS SKIN CONDITION	
	HIGH BLOOD PRESSURE			OPEN SORES or WOUNDS	
	STROKE - WHEN			SKIN RASH (WHERE)	
	ARTERIOSCLEROSIS			EAISY BRUISING	
	ANEURYSM			RECENT FRACTURES	
	LIGHTHEADNESS			ALLERGIES	
	HEADACHES/MIGRAINS			SENSITIVITIES	
	THROMBOSIS			FIBROMYALGIA	
	VARCOSE VEINS			LIMITED RANGE OF MOTION	
	PHIEBITIS			TMJ	
	ASTHMA			CARPLE TUNNEL SYNDROME	
	CHRONIC BRONCHITIS			TENNIS ELBOW	
	EMPHYSEMA			RECENT FRACTURES	
	MULTIPLE SCLEROSIS			JOINT REPLACEMENT	
	PARKINSON'S			WHEN (any problems)	
	NUMBNESS			SCOLIOSIS	
	PARALYSIS			KYPHOSIS/LORDOSIS	
	EDEMA			DIABETES MELLITUS	
	HERNIA			Ctrl by Medication or diet What meds	
	SWOLLEN GLANDS			OTHER_____	

Please explain any condition that you have marked above _____

_____

_____

14. Is there anything else about your health history that you think would be useful for your massage practitioner to know 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 the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

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 or physical ailment that I am aware of. I understand that massage therapists 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 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 _____

Signature of Massage Therapist_____Date _____