Client Intake Form – Therapeutic Massage

Client Information

Name Phone (cell/day)

Address

Email DOB Age:

City/State/Zip

Emergency Contact Name Phone Relationship Occupation Referred by:

Health Information

Are you taking any medications? yes no If yes, please list:

Any allergies? (oils, lotions, nuts, fruits, skin, etc.)

yes no

If yes, please list:

Are you pregnant? yes no

If yes, how many months: Due date:

Are you you currently under medical supervision or receiving other medical interventions? yes no

If yes, please describe:

Areas of swelling Autoimmune disorder Back / neck problems Bleeding disorders Blood clots

Bruise easily Bursitis Cancer

Contagious condition

Decreased sensation

yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no

Diabetes Fibromyalgia Headaches Heart condition Hypertension Kidney disease

Multiple sclerosis Neurological condition Neuropathy Osteoarthritis

yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no

Osteoporosis Phlebitis Sciatica Seizures Stroke Tendinitis

TMJ disorder Varicose veins Vertigo / dizziness

yes no yes no yes no yes no yes no yes no yes no yes no yes no

Areas of broken skin? (e.g. rash, wounds) yes no If yes, where?

History of joint replacement surgery? yes no Which joint(s) ?

Recent injuries or medical procedures in the past 2 years? yes no Please describe:

Please describe any other injuries or health conditions:

Massage Information

Have you had professional massage before? yes no

How recently?

Reason for seeking massage:

Relaxation Specific problem

*Please indicate any areas of discomfort*

How much pressure do you prefer?

Light Medium

Firm

*By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.*

Client Signature

Date

Therapist Signature

Date