## **Massage Therapy Client Intake Form**



## **CONSENT FOR CARE**

Name:			Date:		
Address:			Referred By:		
City: State:		Ziŗ	: Date of Birth:		
Mobile Phone #		Home #	Work #		
Email:					
Employer:			Occupation:		
Emergency Contact:			Phone#		
Please take a moment to accurately an	swer the fol	lowing que	stions regarding current and past medi	cal history.	
Have you ever received a professional r	nassage?	Yes No	If so, how long ago	)?	
Do you have diabetes?	Yes No		Do You have frequent headaches?	Yes No	
Are you pregnant?	Yes No		Do you suffer from arthritis?	Yes No	
Do you suffer from epilepsy/seizures?	Yes No		Do you have osteoporosis?	Yes No	
Do you have any allergies?	Yes No		Do you have varicose veins?	Yes No	
Do you have high blood pressure?	Yes No		Have you ever had a heart attack?	Yes No	
Have you ever had a stroke?	Yes No		Do you bruise easily?	Yes No	
Do you have any back/neck pain?	Yes No		Are you sensitive to touch in any are	ea? Yes No	
Have you ever suffered any serious inju	ries or traum	na? Yes	No If so, how long ago?		
Have you ever had any type of surgery?		Yes	No If so, how long ago?		
Are you currently taking any type of ME	DICATION w	hatsoever?	Yes No If so, please explain.		
Do you currently have any pain, sorene	ss, or illnesse	es not ment	oned that may need to be discussed?	Yes No	
		/			
Please provide details in the space below to any questions answered with a "YES".					
Reason for initial visit:					
<ul> <li>I fully understand that my massage therapist is not a physician and cannot diagnose or prescribe towards</li> </ul>					

- I fully understand that my massage therapist is not a physician and cannot diagnose or prescribe towards medical conditions or disease.
- I acknowledge that massage is not a substitute for medical care, examinations, or diagnosis by a healthcare provider.
- I have stated any and all known medical conditions above and agree to inform my practitioner of any changes with my health status.
- I am aware of the benefits and the risks of massage, and I give my consent for massage.
- I understand that there is no implied or stated guarantee of the success or effectiveness for massage sessions.
- I understand that the client/therapist relationship will be held in strict confidence.

Client Signature:	Date:
Practitioner Signature:	Date:
CONSENT TO TREATMENT OF A MINOR: By my signature below, administer massage therapy to my child or dependent and all about the best of my knowledge.	
Parent or Guardian Signature:	Date: