Therapeutic Massage – Client Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City, State, Zip _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

Physician _____ Phone _____

Massage Information

How did you hear about us? _____

Have you ever had a professional massage before? ☐yes ☐no

If yes, how often to you receive massage therapy? _____

If yes, do you have a style or pressure preference? ☐yes ☐no

Specify : ☐ light pressure ☐ medium pressure ☐ deep pressure

☐ trigger point therapy ☐ energywork

☐ Other _____

What Type of massage are you seeking today?

☐ Relaxation ☐ Deep Tissue/Therapeutic ☐ Pregnancy

☐ Senior ☐ Integrated Bodywork (*functional*)

☐ Other _____

Are you sensitive to fragrances or perfumes? ☐ yes ☐ no

Do you have sensitive skin? ☐ yes ☐ no

Do you wear contact lenses? ☐ yes ☐ no

Do you exercise regularly? ☐ yes ☐ no

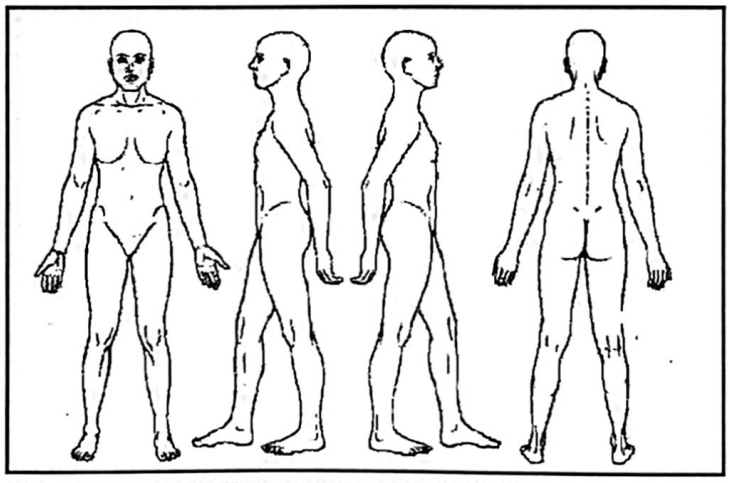
If so, what type(s)? _____

What are your common areas of pain or tension?

_____

_____

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



Medical History

Do you suffer from chronic or persistent pain/discomfort?

_____

If so, for how long? _____

Do you know what caused it or when then symptoms seem to get worse or better? _____

_____

Do you see a chiropractor? ☐ yes ☐ no

If so, how often? _____

Are you currently under medical care? ☐ yes ☐ no

Are you currently taking any prescription medication? If so, for what? _____

_____

_____

Please indicate any conditions that you have had or currently have:

☐ headaches, migraines	☐ varicose veins
☐ allergies, sensitivity	☐ pregnancy
☐ arthritis, tendonitis	☐ blood clots
☐ cancer, tumors	☐ neck / back injuries
☐ TMJ problems	☐ diabetes
☐ abnormal skin condition	☐ paralysis
☐ heart/circulation problems	☐ fibromyalgia
☐ joint replacement / surgery	☐ numbness
☐ high / low blood pressure	☐ sprains, strains
☐ major accident	☐ recent injuries

☐ lack of or reduced feeling / sensation _____

Explain any conditions that you have marked above:

_____

_____

_____

Clear Form

Informed Consent Form

I, (Client's name) _____, **have chosen to consent with and hereby give consent for massage therapy to be provided by (therapists name)** ERICA LOPEZ **who I understand is a member of AMTA (America Massage Therapy Association) and licensed by the state of Florida.**

I have provided a detailed medical history. I do not expect the therapist to have foreseen any previous or pre-existing conditions that I have mentioned.

I understand that massage may provide benefits for certain conditions, but results are not guaranteed. These benefits may include, relief of muscular tension, relaxation, reduction in the symptoms of stress-related conditions and provisions of general wellbeing.

I also understand that massage therapy may produce side effect such as muscle soreness, mild-bruising, increased awareness of areas of pain and light-headedness amongst other possible temporary outcomes.

I am aware that the therapist does not diagnose illness, prescribe medications nor physically manipulate the spine nor its immediate articulations.

The therapist understands that I have the right to question procedures used and to receive and explanation of any procedures that the therapist performs.

I will tell the therapist about any discomfort I may experience during the session and understand that the therapy will be adjusted accordingly.

PRINT Client Name: _____

Client or (guardian's) Signature: _____

Therapist's Signature: Erica Lopez

Date: _____