Healthy Healing
Massage Therapy

Client Intake Form – Therapeutic Massage

Personal Information:

Name _____ Phone(Day) _____ Phone(Eve)_____

Address _____

City/State/Zip _____

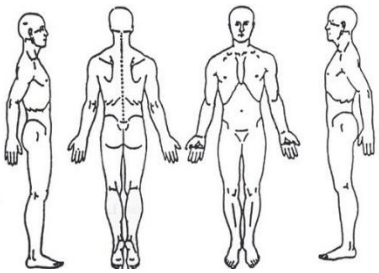
Email _____ Date of Birth _____ Occupation _____

Referred by _____ Emergency Contact _____

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

Date of Initial Visit _____

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, explain _____
3. Do you have any allergies to oils, lotions or ointments? Yes No
   If yes, 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 work station, computer or driving? Yes No
   If yes, please describe _____
7. Do you experience stress in your work, family or other aspect of your life? Yes No
   If yes, how do you think this has affected your health?
   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other _____
8. 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 the specific areas you would like the massage therapist to concentrate on during the session.