Client Intake Form – Therapeutic Massage

Please complete this form before appointment

Client Information

Full Name *

First Name Middle Name Last Name

Email *

example@example.com

Phone Number *

Please enter a valid phone number.

Date of Birth *

Month Day Year

Age

Address *

City/State/Zip *

Emergency Contact Name *

Middle Name Last Name

First Name

Emergency Contact Phone *

Please enter a valid phone number.

Emergency Contact Relationship *

Occupation

Referred by

Health Information

Are you taking any medications? *

- ◯ Yes
- ◯ No

Please list medications

Any allergies? *

- ◯ Yes
- ◯ No

Please list allergies

Are you pregnant? *

- ◯ Yes
- ◯ No

How many months pregnant?

Pregnancy due date

Month Day Year

Are you currently under medical supervision or receiving other medical interventions? *

- ◯ Yes
- ◯ No

Please describe

Health conditions

- ☐ Areas of swelling
- ☐ Autoimmune disorder
- ☐ Back/neck problems
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ Bruise easily
- ☐ Bursitis
- ☐ Cancer
- ☐ Contagious condition
- ☐ Decreased sensation

- [ ] Fibromyalgia
- [ ] Headaches
- [ ] Heart condition
- [ ] Hypertension
- [ ] Kidney disease
- [ ] Multiple sclerosis
- [ ] Neurological condition
- [ ] Neuropathy
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Phlebitis
- [ ] Sciatica
- [ ] Seizures
- [ ] Stroke
- [ ] Tendinitis
- [ ] TMJ disorder
- [ ] Varicose veins
- [ ] Vertigo/dizziness

Areas of broken skin? *

- ○ Yes
- ○ No

Where?

History of joint replacement surgery? *

- ○ Yes
- ○ No

Which joint(s)?

Recent injuries or medical procedures in the past 2 years? *

- ○ Yes
- ○ No

Describe recent injuries or procedures

Please describe any other injuries or health conditions

Massage Information

Have you had professional massage before? *

- ○ Yes
- ○ No

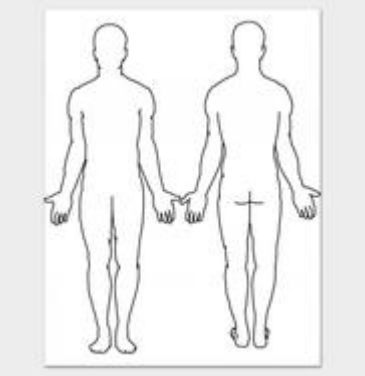
How recently have you had professional massage?

Reason for seeking massage

How much pressure do you prefer?

- ☐ Light
- ☐ Medium
- ☐ Firm
- ☐ Deep

Body diagram – indicate any areas of discomfort



Consent & Signatures

Signature

Client Signature Date *

Month Day Year

Therapist Signature Date *

Month Day Year

Signature