

Massage Client Intake Form

Personal Information

Name: _____

Date of Birth: _____

Address: _____

Home Phone: _____

Mobile Phone: _____

Email: _____

Occupation: _____

Referred By: _____

Emergency Contact: _____

Emergency Phone: _____



Massage Experience

Have you had a professional massage before? _____

How long have you been receiving massage therapy? _____

Frequency of massages? _____

What are your goals for treatment? _____

Current Health

Reason for initial visit _____

Do you exercise regularly and/or participate in any sports? _____

If yes, what kind of exercise/sports? _____

Do you sit for long hours at a workstation, computer or driving? _____

If yes, describe _____

Are you experiencing tension, stiffness, discomfort, or pain? _____

If yes, describe _____

Have you recently had an injury, surgery or areas of inflammation? _____

If yes, describe _____

Do you have sensitive skin? _____

Do you have allergies to any oils, lotions or ointments? _____

If yes, please explain _____

List any medications you are currently taking _____

List any known allergies _____

Health History

Musculoskeletal

- Bone or joint disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches
- Osteoporosis

Circulatory

- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

Respiratory

- Breathing Difficulty/Asthma
- Emphysema
- Allergies, specify:
- Sinus Problems

Nervous System

- Shingles
- Numbness/Tingling
- Pinched Nerve
- Chronic Pain
- Paralysis
- Multiple Sclerosis
- Parkinson's Disease

Reproductive

- Pregnant, stage _____
- Ovarian/Menstrual Problems
- Prostate

Skin

- Allergies, specify:
- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold Sores

Digestive

- Irritable Bowel Syndrome
- Bladder/Kidney Ailment
- Colitis
- Crohn's Disease
- Ulcers

Psychological

- Anxiety/Stress Syndrome
- Depression

Other

- Cancer/Tumors
- Diabetes
- Drug/Alcohol/Tobacco Use
- Contact Lenses
- Dentures
- Hearing Aids

Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above : _____

I understand that the massage therapy I am given is for the purpose of stress reduction, relief from muscular tension or spasm, and/or improving circulation. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical or mental disorders; nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments I have.

Signed: _____ Date: _____