



MASSAGE INTAKE FORM

Disclaimer: Thank you for your interest in being a client of Chiaki L. ☐ or Jeremy H. ☐ .
Information collected about new clients is confidential and will be treated accordingly.

CLIENT INFORMATION

Name: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone (cell/day): _____ DOB: _____ Age: _____

Emergency Contact: _____ Phone: _____

Occupation: _____ Referred by: _____

HEALTH INFORMATION

Are you taking any medications? ☐ Yes ☐ No

If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ Yes ☐ No

If yes, please list: _____

Are you pregnant? ☐ Yes ☐ No

If yes, how many months: _____ Due date: _____

Are you currently under medical supervision or other medical interventions? ☐ Yes ☐ No

If yes, please describe: _____

Areas of broken skin? (e.g., rash, wounds) ☐ Yes ☐ No

If yes, where? _____

History of joint replacement surgery? ☐ Yes ☐ No

If yes, which joint(s)? _____

Do you have any of the following? (check all that apply)

- | | | |
|---|---|--|
| ☐ Areas of swelling | ☐ Diabetes | ☐ Osteoporosis |
| ☐ Autoimmune disorder | ☐ Fibromyalgia | ☐ Phlebitis |
| ☐ Back / neck problems | ☐ Headaches | ☐ Sciatica |
| ☐ Bleeding disorders | ☐ Heart condition | ☐ Seizures |
| ☐ Blood clots | ☐ Hypertension | ☐ Stroke |
| ☐ Bruise easily | ☐ Kidney disease | ☐ Tendinitis |
| ☐ Bursitis | ☐ Multiple sclerosis | ☐ TMJ disorder |
| ☐ Cancer | ☐ Neurological condition | ☐ Varicose veins |
| ☐ Contagious condition | ☐ Neuropathy | ☐ Vertigo / dizziness |
| ☐ Decreased sensation | ☐ Osteoarthritis | _____ |

Recent injuries or medical procedures in the past 2 years? ☐ Yes ☐ No

If yes, please describe: _____

Please describe any other injuries or health conditions:

MESSAGE INFORMATION

Have you had a professional massage before? ☐ Yes ☐ No

How recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem: _____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please list and describe any areas of discomfort:

ACKNOWLEDGMENT & RELEASE

By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

CLIENT SIGNATURE

Signature: _____ Date: _____

Print Name: _____