



Massotherapy
Pain Release

Client Intake Form – Therapeutic Massage

Personal Information:

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

Address _____ City/State/Zip _____

Date of Birth _____ Occupation _____ work phone _____

Email _____ Emergency Contact Name _____

Address _____ Emergency phone number _____

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, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes _____ No _____

If yes, please 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 workstation, computer, or driving? Yes If yes, please describe _____ No _____

muscle tension ()
anxiety ()
insomnia ()
irritability () other _____

7. Do you perform any repetitive movement in your work, sports, or hobby? If yes, please describe _____ Yes _____ No _____

9. Is there a _____

8. Do you experience stress in your work, family, or other aspect of your life? If yes, how do you think it has affected your health? _____ Yes _____ No _____

particular area of the _____

body where you are experiencing tension, stiffness, pain or other discomfort? Yes No _____

If yes, please identify _____

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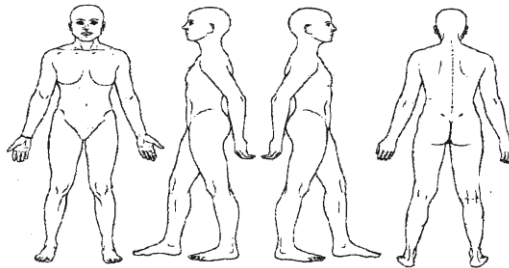
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10. Do you have any particular goals in mind for this massage session? Yes No If yes, please explain _____

11.

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



Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

Are you currently under medical supervision? Yes No If yes, please explain

11. Do you see a chiropractor? Yes No If yes, how often?

12. Are you currently taking any medication? Yes No

If yes, please list _____

13. Please check any condition listed below that applies to you:

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> pregnancy If yes, how many months? _____ |
| <input type="checkbox"/> atherosclerosis | |



Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension.

If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____

Date _____

Signature of Massage Therapist _____

Date _____