■ Celestial Chakra Wellness ■

Massage Therapy Client Intake Form

Client Information

Name: _____

Date of Birth: ____ / ____ / _____ Age: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Health History (Please check all that apply)

■ High blood pressure
■ Low blood pressure / dizziness
■ Heart condition / pacemaker
■ Circulatory issues / blood clots / varicose veins
■ Diabetes
■ Cancer (current or past)
■ Fibromyalgia
■ Arthritis / joint replacement
■ Osteoporosis
■ Epilepsy or seizures
■ Migraines / frequent headaches
■ Asthma / breathing difficulties
■ Autoimmune disorder (Lupus, MS, etc.)
■ Skin conditions (eczema, psoriasis, rash, infection)
■ Recent injury (sprains, fractures, etc.)
■ Recent surgery (last 12 months)
■ Pregnancy
■ Allergies (please list): _____
■ Other: _____

Current Concerns & Preferences

Are you currently under medical care? ■ Yes ■ No
If yes, explain: _____

Areas of focus / discomfort (check all that apply):
■ Neck ■ Shoulders ■ Back (upper / mid / lower) ■ Hips
■ Arms ■ Hands ■ Legs ■ Feet
■ Other: _____

Pressure preference:
■ Light ■ Medium ■ Firm / Deep

Lifestyle & Wellness

Do you experience frequent headaches or migraines? ■ Yes ■ No
Do you have difficulty sleeping? ■ Yes ■ No
Stress level (1–10): _____
Exercise routine: ■ Rarely ■ Occasionally ■ Regularly
Occupation (may affect posture / tension): _____
How often do you receive massages? _____
Is this your first professional massage? ■ Yes ■ No

Additional Notes

_____

_____

_____

Consent

I confirm the information provided is accurate and complete. I will inform my therapist of any changes to my health status.

Client Signature: _____ Date: _____