Massage Intake Form

Please complete this information to help the therapist get to know you better and so your therapy can be customized to your needs. All of this information is important because it describes your lifestyle. This information is confidential is will only be used in the development of your massage therapy treatment plan.

Client Information:

Name:_____ Date of Birth:_____
Address:_____ City:_____
State:_____ Zip:_____ Home Phone:_____ Cell Phone:_____
Email:_____ Occupation:_____

Emergency Contact:_____ Phone Number:_____

Health History:

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork, may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

□ **Yes** □ **No** Have you ever experienced a professional massage? If "Yes" how recently and how often?_____

□ **Yes** □ **No** Are you wearing contact lenses?

□ **Yes** □ **No** Are you wearing dentures?

□ **Yes** □ **No** Are you very sensitive to touch or pressure in any area?

Please specify: _____

_____

□ **Yes** □ **No** Do you suffer from back pain?

□ **Yes** □ **No** Do you frequently suffer from stress?

□ **Yes** □ **No** Do you bruise easily?

□ **Yes** □ **No** Do you experience frequent headaches?

□ **Yes** □ **No** Have you had any broken bones in the past 2 years?

□ **Yes** □ **No** Have you been in an accident in the past 2 years?

□ **Yes** □ **No** Have you suffered any injuries in the past 2 years?

□ **Yes** □ **No** Do you suffer from arthritis?

□ **Yes** □ **No** Do you have tension or soreness in a specific area?

Please specify: _____

_____

□ **Yes** □ **No** Do you have diabetes?

□ **Yes** □ **No** Do you have high blood pressure?

□ **Yes** □ **No** If "yes" to previous question, are you under medication for this?

□ **Yes** □ **No** Do you have cardiac or circulatory problems?

□ **Yes** □ **No** Had numbness or stabbing pains anywhere in the last 3 months?

□ **Yes** □ **No** Do you suffer from epilepsy or seizures?

□ **Yes** □ **No** Do you suffer from joint swelling?

□ **Yes** □ **No** Have you ever had surgery?

□ **Yes** □ **No** Do you have varicose veins?

□ **Yes** □ **No** Do you have any contagious diseases?

□ **Yes** □ **No** Do you have osteoporosis

□ **Yes** □ **No** Are you pregnant?

□ **Yes** □ **No** Do you have any other medical conditions to be aware of?

Please specify: _____

_____

Allergies (nuts, scents, etc.)_____ Sensitivity to heat? □ **Yes** □ **No**
Does your current occupation involve long periods of any of the following? ___Sitting ___Standing ___Computer Work
Do you have sensitive skin? □ **Yes** □ **No**
Do you exercise regularly? □ **Yes** □ **No**
If so, what type(s)? _____

Are you currently taking any prescription medication? □ **Yes** □ **No**
If yes, for what condition?_____

Massage Preferences:

Are you comfortable with having massage done on the following areas:
Gluteal (above the sheet) □ **Yes** □ **No** Abdomen □ **Yes** □ **No** Pectoral Muscles (Upper chest) □ **Yes** □ **No** Feet □ **Yes** □ **No** Face/Head □ **Yes** □ **No**

Do you have a pressure preference? ___ Light ___ Medium ___ Deep

Consent for Care:

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.

Client's Signature:_____ Date:_____