CLIENT INTAKE FORM for Massage Therapy – confidential
(Please write or print clearly)

Name _____ Date of initial visit _____

Address _____

_____

Phone: Home_____ Work _____ Cell _____

E-mail Address _____ DOB _____

Referred by _____ Occupation _____

Emergency contact _____ Phone _____

Physician _____ Phone _____

Other health care provider _____

1. Have you had massage therapy before? Yes No

2. For women: Are you pregnant? Yes No If yes, how many months? _____

3. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain _____

4. Do you have allergic reactions to oils, lotions, ointments, or other substances?

   If yes, please explain _____

5. Do you wear contact lenses ( ) dentures ( ) a hearing aid ( )?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   How would you describe your stress level? Low Medium High Very high

   If high, how do you think stress has effected your health? Muscle tension ( ) anxiety ( )

   insomnia ( ) irritability ( ) other ( )

9. Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort? Yes No

   If yes, please identify _____

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

10. Are you currently under medical supervision? Yes No

    If yes, please explain _____

11. Are you currently taking any medication? Yes No

If yes, please list _____

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

____ Skin condition (e.g., acne, rash, skin cancer, allergy, easy bruising, contagious condition)

____ Allergies

____ Recent accident, injury, or surgery (e.g., whiplash, sprain, broken bone, deep bruise)

____ Muscular problems (e.g., tension, cramping, chronic soreness)

____ Joint problems (e.g., osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, recent dislocation)

____ Lymphatic condition (e.g., swollen glands, nodes removed, lymphoma, lymphedema)

____ Circulatory or blood conditions (e.g., atherosclerosis, varicose veins, phlebitis, arrhythmias, high or low blood pressure, heart disease, recent heart attack or stroke, anemia)

____ Neurologic condition (e.g., numbness or tingling in any area of the body, sciatica, damage from stroke, epilepsy, multiple sclerosis, cerebral palsy)

____ Digestive conditions (e.g., ulcers)

____ Immune system conditions (e.g., chronic fatigue, HIV/AIDS)

____ Skeletal conditions (e.g., osteoporosis, bone cancer, spinal injury)

____ Headaches (e.g., tension, PMS, migraines)

____ Cancer

____ Emotional difficulties (e.g., depression, anxiety, panic attacks, eating disorder, psychotic episodes). Are you currently seeing a psychotherapist for this condition? Yes No

____ Previous surgery, disease, or other medical condition that may be affecting you now (e.g., polio, previous heart attack or stroke, previously broken bones)

Comments

_____

_____

_____

13. Is there anything else you would like me to know to plan a safe and effective massage session for you?

_____

_____

_____

14. Has your physician or health care provider recommended massage for any condition listed above? Yes No

    If yes, please explain _____

15. Do you have any particular goals in mind for this massage session related to any of the conditions mentioned above? Yes No

    If yes, please explain _____

I understand that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. It may be beneficial for my massage practitioner to speak to my doctor about my medical condition to determine how massage may help the healing process, and to avoid worsening the condition. I will be asked for permission to contact my doctor, if the massage practitioner thinks that it might be useful. I also understand that it is my responsibility to keep my massage practitioner informed of any changes in my health, and any medications that I may begin to take in the future.

Signature _____ Date _____