

Client Intake Form – Therapeutic Massage

Personal Information:

Referred by? _____

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

Address _____

City/State/Zip _____

email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

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 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

If yes, how do you think it has affected your health?

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

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain

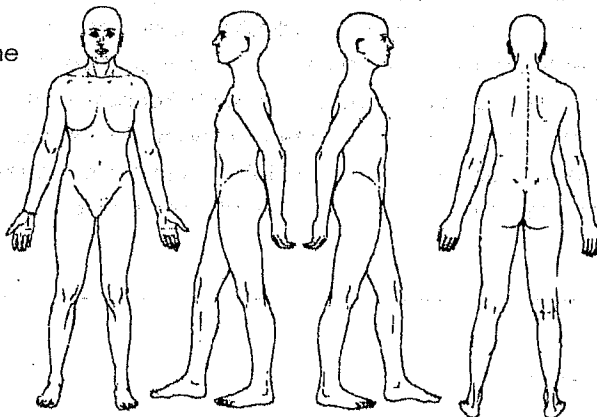
or other discomfort? Yes No

If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain _____

Circle any specific areas 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.

11. Are you currently under medical supervision? Yes No

If yes, please explain _____

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

13. Are you currently taking any medication? Yes No

If yes, please list _____

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

☐ contagious skin condition

☐ phlebitis

☐ open sores or wounds

☐ deep vein thrombosis/blood clots

☐ easy bruising

☐ joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis

☐ recent accident or injury

☐ osteoporosis

☐ recent fracture

☐ epilepsy

☐ recent surgery

☐ headaches/migraines

☐ artificial joint

☐ cancer

☐ sprains/strains

☐ diabetes

☐ current fever

☐ decreased sensation

☐ swollen glands

☐ back/neck problems

☐ allergies/sensitivity

☐ Fibromyalgia

☐ heart condition

☐ TMJ

☐ high or low blood pressure

☐ carpal tunnel syndrome

☐ circulatory disorder

☐ tennis elbow

☐ varicose veins

☐ pregnancy If yes, how many months?

☐ 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 _____

Massage Therapist Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. It is our desire to be effective and fair to all of our clients and out of consideration for massage therapists' time; we have put the following policies into effect:

24 hour advance notice: It **IS** required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment.

If you are unable to give the massage therapist a reasonable time of advance notice you may be charged 50% for your missed appointment.

No-shows: Anyone who either forgets or consciously chooses to forgo their appointment with no contact will be considered a "**no-show**". They will be charged the **FULL** amount for their "missed" appointment and future service will be denied until payment is made.

Arriving late: Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, the massage therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session; however we will do our best to satisfy the scheduled time.

Out of respect and consideration to the massage therapist and other customers, please plan your visit accordingly. Please arrive 10 min early on your first visit to fill out an intake form. We appreciate your business and look forward to seeing you!

Patient Name: _____

Patient Signature: _____

Date: _____