

Massage Client Intake

Personal Information

Name _____ Date of Birth _____ Phone _____

Address _____ City/State/Zip _____

Email _____ Occupation _____

Emergency Contact Name _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you currently taking any medications? Yes No

If yes, please list name and use: _____

Are you currently pregnant? Yes No

If yes, how far along? _____

What makes it better? _____

What makes it worse? _____

Have you been in a accident? Yes No

If yes, please explain? _____

Please indicate any of the following that apply to you.

- | | |
|--------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/ Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Sprains or Strains |

Please explain any conditions you have marked above:

Massage Information

Have you had a professional massage before? Yes No

What type of massage are you seeking?

- Relaxation Therapeutic/Deep Tissue

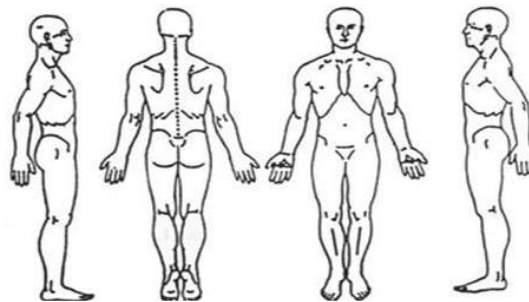
What pressure do you prefer?

- Light Medium Deep

Do you have any allergies or sensitivities to lotions/ oils?

- Yes No If yes, please explain _____

Please circle any area of discomfort



By signing below, you agree to the following.

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time. All minors must have signed consent by a legal guardian and minors under 17 must have a parent present during the entire session. *Draping will be used during the entire session- only the area being worked will be uncovered. *

Client Signature _____

Date _____

I understand that the massage I receive is provided for the basic purpose of relaxation of muscular tension. If I experience any pain or discomfort during the 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.