Massage Intake Form

Name _____ Phone_____

Address_____City/State/Zip_____

Email_____ Date of Birth_____ Occupation_____

Emergency Contact_____ Phone_____

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 if yes please explain_____?

3. Are you allergic to essential or massage oils?

4. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( )?

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

6. Do you perform any repetitive movement in your work, sports, or hobby? Yes No If yes, please describe

7. 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

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

If yes, please identify_____

9. Do you have any particular goals for this massage session? Please explain_____

Please check any condition listed below that applies to you:

( ) phlebitis

( ) deep vein thrombosis/blood clots

( ) contagious skin condition

( ) open sores or wounds

( ) easy bruising

( ) recent accident or injury

( ) recent fracture

( ) recent surgery

( ) artificial joint

( ) sprains/strains

( ) current fever

( ) swollen glands

( ) allergies/sensitivity

( ) heart condition

( ) high or low blood pressure

( ) circulatory disorder

( ) varicose veins

( ) atherosclerosis

( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis

( ) diabetes

( ) decreased sensation

( ) back/neck problems

( ) Fibromyalgia

( ) TMJ

( ) carpal tunnel syndrome

( ) tennis elbow

( ) pregnancy If yes, how many months?_____

( ) osteoporosis

( ) epilepsy

( ) headaches/migraines

( ) cancer

Medical History

10. Are you currently under medical supervision? Yes No If yes, please explain

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

12. Are you currently taking any medication? Yes No

If yes, please list_____

13. 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 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 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_____