THERAPEUTIC MASSAGE CLIENT INTAKE FORM

Personal Information:
Name_____Phone (Day)_____Phone (Eve)_____
Address_____
City/State/Zip_____
e-mail_____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 to 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 work station, 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 requests in mind for this massage session? Yes No
    If yes, please explain_____

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Medical History

In order to plan a massage session that is safe and effective,
I need some 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 taking any medications? Yes No
    If yes, please list _____
    _____

Do you have a history of the following? Please check if "yes".

Musculoskeletal
__ easy bruising
__ recent fracture
__artificial joint
__sprains/strains
__osteoporosis
__joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
__back/neck problems
__carpal tunnel syndrome
__clenching or grinding teeth
__jaw pain/clicking/popping
__spinal curvature
__spasms/cramps
__tennis/golf elbow
__TMJ disorder
__whiplash
__herniated disc
__other_____

Neurological
__epilepsy
__headaches/migraines
__decreased sensation
__neuropathy
__numbness/tingling
__dizziness any cause
__chronic pain
__Bell's palsy
__poliomyelitis
__sciatica
__other_____

Autoimmune Disorders
__AIDS
__fibromyalgia
__lupus
__chronic fatigue syndrome
__MS
__other_____

Hepatitis
__A
__B
__C

Digestive
__constipation
__colitis
__irritable bowel syndrome
__gas/bloating
__other_____

Other
__allergies (any)
__sinus problems
__diabetes
__difficulty sleeping
__fatigue
__history of surgeries_____
__cancer/tumors (include any history)_____
__recent surgery_____
__skin rash

Respiratory/Circulatory
__heart condition
__high or low blood pressure
__varicose veins
__atherosclerosis
__phlebitis
__deep vein thrombosis/blood clots
__breathing difficulties
__asthma
__other

Pregnancy
__ If yes, how many months:__
__MD prescription

Payment will be: __Check __Cash __Gift Certificate

I understand that a block of time has been set aside for my treatment and requires me to give no less than 12 hours notification for cancellation; failure to do so could result in a fee or prepayment for my next treatment.
Initials_____

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder. Massage therapists also do not prescribe medical, chiropractic treatment or pharmaceuticals. It is no way intended to be a substitute for professional health care. I have stated all medical conditions of which I am aware, and will update the therapist of any changes in my health status.

Signature:_____Date: _____