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**MASSAGE INTAKE FORM**

Disclaimer: Thank you for your interest in being a client of [SPA/THERAPIST'S NAME]. Information collected about new clients is confidential and will be treated accordingly.

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| **CLIENT INFORMATION** |

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Street Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_

**Phone (cell/day)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referred by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **HEALTH INFORMATION** |

**Are you taking any medications?** [ ]  Yes [ ]  No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any allergies?** (oils, lotions, nuts, fruits, skin, etc.) [ ]  Yes [ ]  No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you pregnant?** [ ]  Yes [ ]  No

If yes, how many months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently under medical supervision or other medical interventions?** [ ]  Yes [ ]  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Areas of broken skin?** (e.g., rash, wounds) [ ]  Yes [ ]  No

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of joint replacement surgery?** [ ]  Yes [ ]  No

If yes, which joint(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following?** (check all that apply)

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| [ ]  Areas of swelling [ ]  Autoimmune disorder[ ]  Back / neck problems[ ]  Bleeding disorders[ ]  Blood clots[ ]  Bruise easily[ ]  Bursitis[ ]  Cancer[ ]  Contagious condition[ ]  Decreased sensation | [ ]  Diabetes[ ]  Fibromyalgia[ ]  Headaches[ ]  Heart condition[ ]  Hypertension[ ]  Kidney disease[ ]  Multiple sclerosis[ ]  Neurological condition[ ]  Neuropathy[ ]  Osteoarthritis | [ ]  Osteoporosis[ ]  Phlebitis[ ]  Sciatica[ ]  Seizures[ ]  Stroke[ ]  Tendinitis[ ]  TMJ disorder[ ]  Varicose veins[ ]  Vertigo / dizziness[ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Recent injuries or medical procedures in the past 2 years?** [ ]  Yes [ ]  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please describe any other injuries or health conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **MASSAGE INFORMATION** |

**Have you had a professional massage before?** [ ]  Yes [ ]  No

How recently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for seeking massage:** [ ]  Relaxation [ ]  Specific problem

**How much pressure do you prefer?** [ ]  Light [ ]  Medium [ ]  Firm

**Please list and describe any areas of discomfort:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ACKNOWLEDGMENT & RELEASE** |

By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

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| **CLIENT SIGNATURE** |

Signature: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_