

MASSAGE INTAKE FORM

Disclaimer: Thank you for your interest in being a client of
Information collected about new clients is confidential and will be treated accordingly.

CLIENT INFORMATION

Name: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone (cell/day): _____ DOB: _____ Age: _____

Emergency Contact: _____ Phone: _____

Occupation: _____ Referred by: _____

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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Areas of swelling | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Back / neck problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tendinitis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> TMJ disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Neurological condition | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Contagious condition | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Vertigo / dizziness |
| <input type="checkbox"/> Decreased sensation | <input type="checkbox"/> Osteoarthritis | _____ |

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

If yes, please describe: _____

Please describe any other injuries or health conditions:

MESSAGE 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:

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.

CLIENT SIGNATURE

Signature: _____ Date: _____

Print Name: _____