Client Intake Form

Date_______________
Name____ Date of Birth_________________
Home Phone_______________________Cell Phone_________________________________
Work Phone ____
Address____
City/State/Zip____
Email____
Relationship Status: ____Single ____Married ____Partnered ____Other
Occupation____
Referred by ____
Emergency Contact Name____________________________Phone___________________
Physician's Name____________________________________Phone___________________

The following information will be used to help me plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Current Health

Have you had a professional massage before? Yes No

What are your goals for treatment?____

Do you exercise regularly and/or participate in any sports? Yes No
If yes, what kind of exercise/sports?____

Do you perform any repetitive movement in your work, sports or hobby? Yes No
If yes, describe____

Do you experience stress in your work, family, or other aspect of life? Yes No
If yes, describe____

Are you experiencing tension, stiffness, discomfort or pain? Yes No
If yes, describe____

Have you recently had an injury, surgery, or areas of inflammation? Yes No
If yes, describe____

Do you have sensitive skin? Yes No

Do you have any allergies to oils, lotions or essential oils? Yes No
If yes, please explain____

Are you currently under medical supervision? Yes No
If yes, please explain____

List any medications you are currently taking____
____

List any known allergies____

Is there anything else about your health history that you think would be useful for me to know to plan a safe and effective massage? ____
____

Health History-
Please indicate your past and current health issues by marking a P or a C.

Musculoskeletal
____ Bone or joint disease
____ Tendonitis/Bursitis
____ Arthritis/Gout
____ Jaw Pain/TMJ
____ Lupus
____ Spinal Problems
____ Migraines/Headaches
____ Osteoporosis

Circulatory
____ **H**eart Condition
____ Phlebitis/Varicose Veins
____ Blood Clots
____ High/Low Blood Pressure
____ Lymphedema
____ Thrombosis/Embolism

Reproductive
____ Pregnant, stage______
____ Ovarian Issues
____ PMS/Menstrual Issues
____ Prostate Issues

Respiratory
____ Breathing Difficulty/Asthma
____ Emphysema
____ Allergies
____ Sinus Problems

Nervous System
____ Shingles
____ Numbness/Tingling
____ Pinched Nerve
____ Chronic Pain
____ Paralysis
____ Multiple Sclerosis
____Parkinson's Disease

Other
____ Cancer, Tumors
____ Diabetes
____ Contact Lenses
____ Dentures
____ Hearing Aids

Skin
____ Allergies
____ Rashes
____ Cosmetic Surgery
____ Athlete's Foot
____ Herpes/Cold Sores

Digestive
____ IBS
____ Bladder Ailment
____ Colitis
____ Crohn's Disease
____ Ulcers

Psychological
____ Anxiety
____ Depression

Client Agreement and Consent

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage practitioners are not qualified to diagnose or treat any mental illness, and that nothing said in the course of the session given should be construed as such. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my health status and understand that there shall be no liability on the practitioner's part should I fail to do so.

____
Client Signature Date