MASSAGE CLIENT INTAKE FORM

PERSONAL INFORMATION

Name: _____ Date of birth: _____
Address: _____
City, State, Zip: _____
Home phone: _____ Cell phone: _____
Work phone, ext.: _____
Email: _____
Occupation: _____
Employer: _____
Employer address: _____
Marital status: _____
Referred by: _____
Emergency contact name (relationship): _____
Emergency contact phone: _____
Physician's name and phone: _____

MASSAGE PREFERENCES

Have you had a professional massage before? ❑ Yes ❑ No
If yes, what types of massage have you had (Swedish, shiatsu, deep tissue, etc.)?: _____
How long have you been receiving massage therapy?: _____
Frequency of massages?: _____
What are your goals for treatment?: _____
Any areas you'd not want to be massaged?: _____

CURRENT HEALTH

Reason for initial visit: _____
Do you exercise regularly and/or participate in any sports? ❑ Yes ❑ No
If yes, what kind?: _____
Do you perform any repetitive movement in your work, sports or hobby?
❑ Yes ❑ No
If yes, describe: _____
Do you sit for long hours at a workstation, computer, or driving? ❑ Yes ❑ No
If yes, describe: _____
Do you experience stress at work or in your personal 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 fragrances? ❑ Yes ❑ No
If yes, explain: _____
List any medications you are currently taking: _____

List any known allergies:

CLIENT SIGNATURE: _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

CHECK ALL THAT APPLY

MUSCULOSKELETAL

❑ Bone or joint disease ❑ Tendonitis/Bursitis
❑ Arthritis/Gout ❑ Jaw Pain (TMJ)
❑ Lupus ❑ Spinal Problems
❑ Migraines/Headaches ❑ Osteoporosis

CIRCULATORY

❑ Heart Condition ❑ Phlebitis/Varicose Veins
❑ Blood Clots ❑ High/Low Blood Pressure
❑ Lymphedema ❑ Thrombosis/Embolism

RESPIRATORY

❑ Breathing Difficulty/Asthma ❑ Emphysema
❑ Allergies, specify: ❑ Sinus Problems

NERVOUS SYSTEM

❑ Shingles ❑ Numbness/Tingling
❑ Pinched Nerve ❑ Chronic Pain
❑ Paralysis ❑ Multiple Sclerosis
❑ Parkinson's Disease

REPRODUCTIVE

❑ Pregnant, week _____ ❑ Prostate issues
❑ Ovarian/Menstrual Problems

SKIN

❑ Allergies, specify: ❑ Rashes
❑ Cosmetic Surgery ❑ Athlete's Foot
❑ Herpes/Cold Sores

DIGESTIVE

❑ Irritable Bowel Syndrome ❑ Bladder/Kidney Ailment
❑ Colitis ❑ Crohn's Disease
❑ Ulcers

HEAD/NECK

❑ Headaches/Migraines ❑ Vertigo/Dizziness
❑ Ringing in Ears ❑ Hearing Loss
❑ Vision Problems ❑ Vision Loss

PSYCHOLOGICAL

❑ Anxiety/Stress/PTSD ❑ Depression

OTHER

❑ Cancer/Tumors ❑ Diabetes
❑ Drug/Alcohol/Tobacco Use ❑ Contact Lenses
❑ Dentures ❑ Hearing Aids
❑ Any other medical condition(s) not listed:

Please explain any of the conditions that you have marked above: