# CLIENT INTAKE FORM – THERAPEUTIC MASSAGE

Name _____ Email _____

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

Address _____ City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

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 you currently under medical supervision or receiving other medical interventions? ☐ yes ☐ no

If yes, please describe: _____

| | No | Yes | | No | Yes | | No | Yes |
|---|---|---|---|---|---|---|---|---|
| Areas of swelling | ☐ | ☐ | Diabetes | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Autoimmune disorder | ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Phlebitis | ☐ | ☐ |
| Back / neck problems | ☐ | ☐ | Headaches | ☐ | ☐ | Sciatica | ☐ | ☐ |
| Bleeding disorders | ☐ | ☐ | Heart condition | ☐ | ☐ | Seizures | ☐ | ☐ |
| Blood clots | ☐ | ☐ | Hypertension | ☐ | ☐ | Stroke | ☐ | ☐ |
| Bruise easily | ☐ | ☐ | Kidney disease | ☐ | ☐ | Tendinitis | ☐ | ☐ |
| Bursitis | ☐ | ☐ | Multiple sclerosis | ☐ | ☐ | TMJ disorder | ☐ | ☐ |
| Cancer | ☐ | ☐ | Neurological condition | ☐ | ☐ | Varicose veins | ☐ | ☐ |
| Contagious condition | ☐ | ☐ | Neuropathy | ☐ | ☐ | Vertigo / dizziness | ☐ | ☐ |
| Decreased sensation | ☐ | ☐ | Osteoarthritis | ☐ | ☐ | | | |

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? _____

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: _____

_____

Please describe any other injuries or health conditions: _____

## Massage Information

Have you had professional massage before? ☐ yes ☐ no How recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem

_____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

*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.*

*Please indicate any areas of discomfort*