# Massage Therapy Intake Form



## Client Information

Date _____

Name _____

Address _____

City _____ State ____ Zip _____

E-mail _____

DOB ___/____/____ Age ____ Height _____ Weight _____

Sex ☐ MALE ☐ FEMALE

☐ MARRIED ☐ WIDOWED ☐ SINGLE
☐ SEPARATED ☐ DIVORCED ☐ PARTNERED

Occupation _____

Referred by _____

Primary Physician _____

## Phone Numbers

Home _____ Cell _____

Best time to reach you _____ am _____ pm

**EMERGENCY CONTACT**

Name _____

Home _____ Cell _____

## Massage History

Previous massage experience? ☐ YES ☐ NO

How often? ☐ YEARLY ☐ MONTHLY ☐ WEEKLY

Date of last visit _____

Primary reason for visit? _____

What results would you like to achieve? _____

_____

_____

## Client Condition

When did symptoms appear?_____

_____

What treatment have you already received?

(Circle all that apply)

Medication Surgery Physical Therapy
Chiropractic None Other _____

Level of discomfort Minor 1 2 3 4 5 6 7 8 9 10 Severe

Type of discomfort

Sharp Dull Throbbing Numbness
Aching Shooting Burning Tingling
Cramps Stiffness Swelling Other _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

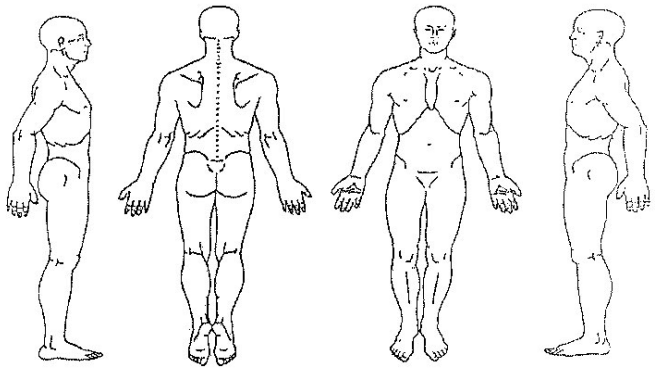
Does it interfere with your (Circle)

Work Sleep Daily Routine Recreation

**Contraindication – Reason not to massage an area**

_____

**On the photo below, mark specific area(s) you would like the massage therapist to concentrate on during today's session.**



**Female Breast massage cannot take place without written consent of client.**

## Health History

**Please mark an (X) for current conditions or a (P) for past conditions**

____ Allergies/Sensitivities
____ Anemia
____ Anorexia
____ Arthritis
____ Asthma
____ Athlete's Foot
____ Birth Control/IUD
____ Blood Clots
____ Breathing Difficulty
____ Bursitis
____ Bronchitis
____ Bulimia
____ Cancer
____ Chemical Dependency
____ Chronic Pain
____ Circulatory Problems
____ Constipation/Diarrhea
____ Diabetes
____ Depression
____ Emphysema
____ Epilepsy
____ Fatigue
____ Fibromyalgia
____ Fractures
____ Glaucoma
____ Head Injuries
____ Hearing Problems/Deafness
____ Heart Disease
____ Hepatitis
____ Hernia
____ Herniated Disk
____ Herpes
____ High Blood Pressure
____ Infectious Diseases
____ Jaw Pain/TMJ
____ Lymphedema
____ Migraine Headaches
____ Mononucleosis
____ Multiple Sclerosis
____ Muscle or Joint Pain
____ Numbness or Tingling
____ Osteoporosis
____ Pacemaker
____ Parkinson's Disease
____ Pinched Nerve
____ Pneumonia
____ Polio
____ Prosthesis
____ Pregnancy
____ Rashes
____ Rheumatoid Arthritis
____ Rheumatic Fever
____ Sinus Problems
____ Skin Condition(s)
____ Sleep Difficulties
____ Spinal Column Disorders
____ Sprains/Strains
____ Stroke
____ Tendonitis
____ Tension/Stress
____ Thyroid Problems
____ Tuberculosis
____ Tumors/Growths
____ Ulcers
____ Varicose Veins
____ Vision Problems/ Contact Lenses
____ Whiplash
____ Other medical conditions not listed
_____
____ Other infectious/ communicable diseases not listed
_____

## Health History (Continued)

Please explain any areas noted on the previous page:

_____

_____

_____

_____

_____

Please list any medical conditions, surgeries, accidents and bone, joint, nerve or muscle diseases or injuries not previously specified.

_____ Date: _____

_____ Date: _____

_____ Date: _____

## Medications

Medications Taken For:

_____

_____

_____

_____

## Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

## Lifestyle

☐ Smoking Packs per day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Cups/day _____
☐ High Stress Level Reason _____

Please list all forms and frequency of stress reduction activities, hobbies, exercise or sports participation:

_____

_____

_____

_____

## FOR FEMALES ONLY:

Are you pregnant? YES ☐ NO ☐ Due Date _____ Note from physician authorizing massage? YES ☐ NO ☐

*** Must have a written note from MD before massage can take place.**

## Privacy Information

**I understand that I will be fully draped at all times except for the areas that are being worked on. If I become uncomfortable for any reason during the massage, I can ask the Therapist to cease the massage and the Therapist will end the session.**

**Information collected by the Therapist will be kept confidential and will not be released without prior written authorization by the client.**

## Authorization

The information above is accurate and complete to the best of my knowledge and I freely give my permission to be massaged.

I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will automatically end the session.

As massage should not be performed under certain medical conditions, I affirm I have been honest and forthcoming regarding my medical conditions.

I have not taken any medications, drugs, or consumed any alcohol that would make massage therapy detrimental to my health.

I agree to inform the therapist of any experience of discomfort during the session so that the pressure and/or strokes can be adjusted to my comfort level.

I agree to inform the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so.

I understand that receiving massage therapy does not deter me from seeking medical treatment for any medical condition.

_____ _____

Signature of Client, Parent, Guardian or Personal Representative (if Client is under 17, Parent or Guardian must sign) Date

_____ _____

Please print name of Client, Parent, Guardian or Personal Representative Relationship to Client