

Massage Intake Form

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Date _____

CLIENT INFORMATION FORM

Name _____ Birth Date _____ Referred by _____

Address _____ City _____ State _____ Zip _____

Telephone (primary) _____ Telephone (other) _____ email _____

Occupation _____ Employer _____ Physician _____

Please answer the following questions by circling the appropriate answer

Have you had a professional massage before?...YES NO

Do you wear contact lenses?.....YES NO

Do you wear dentures?.....YES NO

Do you have arthritis?.....YES NO

Do you have varicose veins?.....YES NO

Do you have blood clots or a history of blood clots?
YES NO

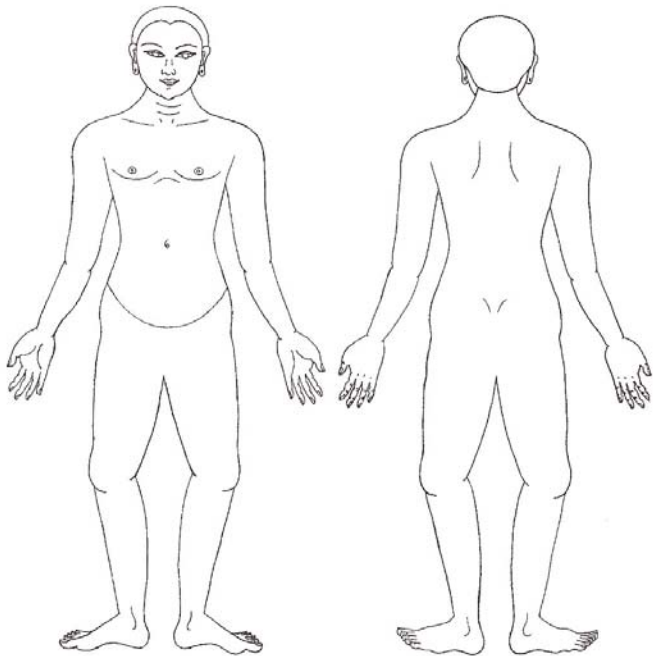
Do you have a history of thrombosis, phlebitis, or aneurism?
YES NO

Do you have heart problems?.....YES NO

Do you have untreated high blood pressure?.....YES NO

Are you pregnant or trying to become pregnant?
YES NO

Do you have any illness, disease or infection, bacterial or viral, which may be contagious and against which the massage therapist should take appropriate precautions to prevent exposure and/or aggravation of the condition (you do not need to specify the nature of the illness or infection).
YES NO



Please circle your problem area on the drawings above.
Indicate your symptoms with these symbols:

Tension - - - - - Cramping // // // // //

Numbness + + + + + Pain >>>>>

(Please complete reverse side)

Are you presently taking medications? ...YES NO If yes, which ones? _____

Are you presently under the care of a medical doctor or health practitioner? ...YES NO

If yes, for what reason(s)? _____

Do you have any other medical condition that the massage therapist should be aware of before giving you massage therapy?

YES NO If yes, please specify: _____

Do you have any skin problems or allergies? ...YES NO If yes, which ones? _____

What physical activities do you regularly participate in? _____

Please detail any recent accidents? _____

Please detail any recent surgeries _____

Do you have any spinal problems? ...YES NO If yes, what is the diagnosis? _____

I understand that if I fail to answer any of these questions, the massage therapist may refuse services.

I, (print name) _____, understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals nor does he/she perform any spinal manipulations. I understand that the massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

I hereby release the massage therapist from any liability for any consequences that may occur as a result of this service.

Signature _____ Date _____

Witness _____ Date _____