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 frangrances? ☐ **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:
☐ Cosmetic Surgery ☐ Rashes
☐ Herpes/Cold Sores ☐ Athlete's Foot

DIGESTIVE

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

PSYCHOLOGICAL

☐ Anxiety/Stress Syndrome ☐ 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 :