client intake form

personal information

name _____ date of birth _____

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

referred by _____

emergency contact name (relationship) _____ phone _____

Are you currently under the care of a physician? ☐ Yes ☐ No

physician's name _____ physician's phone _____

Reason for initial visit _____

massage experience

Have you had a professional massage before? ☐ Yes ☐ No

How long have you been receiving massage therapy? _____

Frequency of massages? _____

Any areas you would like to avoid during the massage?

___ Face ___ Scalp ___ Glutes (Gluteus Muscles)

___ Pecs (Pectoralis Muscles) ___ Other: _____

health history

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, stage _____
- ___ Ovarian/Menstrual Problems
- ___ Prostate

client signature _____

current health

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 desk, computer, or driving? ☐ Yes ☐ No

If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? ☐ Yes ☐ No

If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? ☐ Yes ☐ No

If yes, describe _____

Please rate your current pain level

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Severe

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 ointments? ☐ Yes ☐ No

If yes, please explain _____

List any medications you are currently taking _____

List any known allergies _____

Skin

- ___ Allergies, specify: _____
- ___ Rashes
- ___ Cosmetic Surgery
- ___ Athlete's Foot
- ___ Herpes/Cold Sores

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: _____

date of initial visit _____