Client Intake Form- Therapeutic Massage & Bodywork

Personal Information

Name _____ Phone_____

Mailing Address _____ Date Of Birth _____

Occupation_____ Email _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

The following information will be used to help plan safe and effective massage sessions. It will be kept confidential.

Medical Information

Are you taking any medications? ☐ yes ☐ no

Please list: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Have you had any past/recent surgeries that may affect your massage? ☐ yes ☐ no

Please indicate:_____

_____

Do you currently have any implanted medical devices?

☐ yes ☐ no

If yes, please indicate where the device is located and when it was placed:

_____

Please check any conditions that apply to you:

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Vertigo/Dizziness
☐ Neuropathy
☐ TMJ Disorder
☐ Seasonal Allergies
☐ Easy Bruising
☐ Sciatica
☐ Anxiety/Depression/PTSD
☐ Tendinitis
☐ Fibromyalgia
☐ Autoimmune disease
☐ Stroke
☐ Epilepsy/Seizures
☐ Heart Condition
☐ Kidney Dysfunction
☐ Blood Clots
☐ DVT
☐ Varicose Veins
☐ Numbness
☐ Carpal Tunnel
☐ Shin Splints

Is there any other medical information or history that would be useful for your massage therapist to know?

_____

_____

Do you sit for long hours at a workstation, computer, or driving?

☐ yes ☐ no _____

Do you have trouble lying on your back, front or sides?

☐ yes ☐ no _____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

How recently? _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Firm

Please circle any areas you **are** comfortable having treated:

gluteals (buttocks), pectorals (chest), head/scalp, feet/hands, face

Do you have any skin allergies or sensitivities to lotions or oils?

☐ yes ☐ no _____

Are there any areas (feet, face, abdomen, hands etc.) you **do not** want massaged? ☐ yes ☐ no

Please indicate_____

Do you have any specific goals for massage therapy treatment?

_____

_____

There will be a drape (sheet/blanket) over the breasts of all female clients, and the genital area and gluteal cleavage for all clients at all times.

Any gluteal massage or bodywork will be performed over the drape (sheet/blanket).

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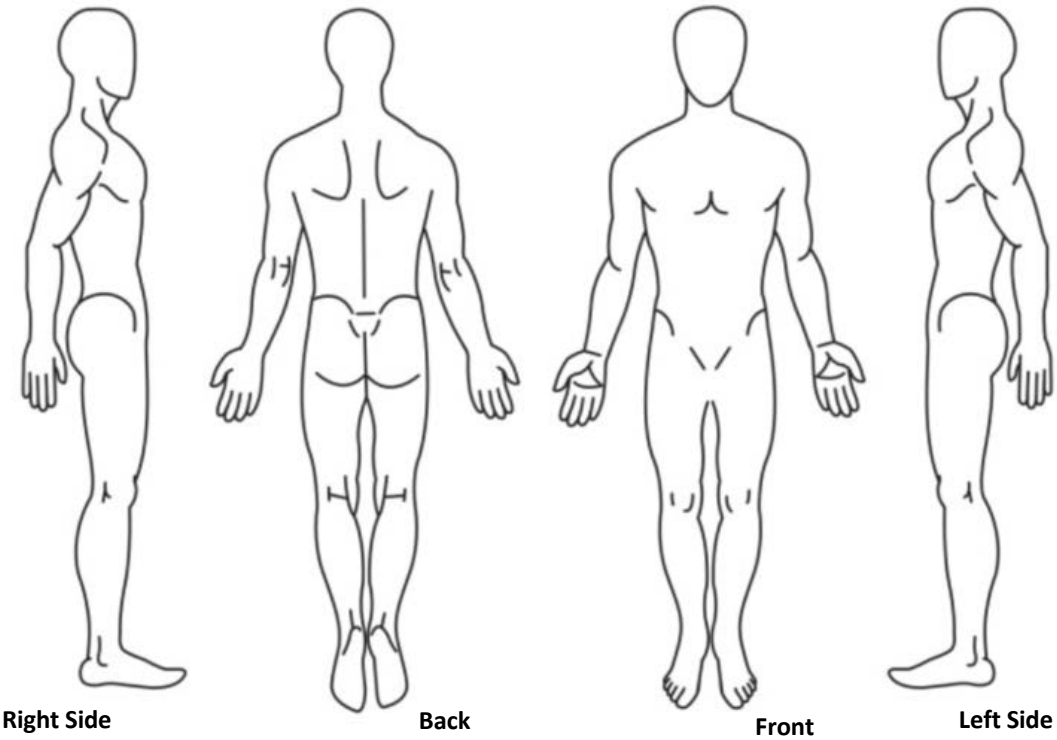

Right Side **Back** **Front** **Left Side**

Please indicate the areas you would like your massage therapist to concentrate on using the body chart or explain here:

_____

_____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Understanding all of this, **I give my consent to receive care**.

Client Signature _____ Date_____

Parent/Legal Guardian Signature _____ Date _____