Client Intake Information

Personal Information

Name_____ Phone (Day)_____ Phone (Eve)_____

Address_____

City/State/Zip_____

Email_____ Date of Birth_____ Occupation_____

Emergency Contact Phone_____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit_____

1. Have you had a professional massage before? Yes No

   If yes, how often do you receive massage therapy?_____

2. Do you have any difficulty lying on your front, back, or side? Yes No

   If yes, please explain_____

3. Do you have any allergies to oils, lotions, or ointments? Yes No

   If yes, please explain_____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe_____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe_____

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

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify_____

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain_____

Medical History

In order to plan a massage session that is safe and effective,
I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No

If yes, please explain_____

12. Do you see a chiropractor? Yes No If yes, how often?_____

13. Are you currently taking any medication? Yes No

If yes, please list_____

14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?

Please explain any condition that you have marked above_____