MASSAGE THERAPY

~ Client Intake Form ~

Name: _____ Phone (Day & Evening): _____

Address: _____
Street City Zip Code

Date of Birth: _____ Occupation: _____ Employer: _____

Marital Status: __ Married __ Single __ Divorced Referred By: _____

Emergency Contact: Name _____ Phone _____

Physician Name: _____ Phone _____

MASSAGE INFORMATION

First Professional Massage: _____Yes _____ No
If yes, how frequently do you get massage: _____

Date of Initial Visit: _____ Do you have any Allergies? _____

Do you have trouble lying on your front or back? _____

Do you sit for long hours at a workstation, computer or driving? ___No ___Yes
If yes, how long? _____

Do you perform any repetitive movement? _____Yes _____ No
If yes, please describe: _____
_____

Do you experience stress in your life? _____Yes _____ No
If yes, do you think it has affected your health? _____
_____

List accidents/injuries, hospitalizations and surgeries: when they occurred and treatment received: _____
_____
_____
_____

Any lingering effects from the above or do you feel you have recovered? _____
_____

Chronic, ongoing pain? _____Yes _____ No
If yes, please describe and any care or treatment you receive:_____
_____
_____

Do activities affect the pain? _____Yes _____No
If yes, please describe: _____

Are you currently being treated medically or taking prescribed drugs? _____Yes _____No
Please describe: _____

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Please circle your level of pain: Low 1 2 3 4 5 6 7 8 9 10 High

Are you allergic to any Lotions or Oils? _____Yes _____No Please Explain:_____

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

MUSCULOSKETAL

Headaches
Joint Stiffness/Swelling
Spasms/Cramps
Broken/Fractured Bones
Back, Hip Pain
Shoulder, Neck, Arm, Hand Pain
Leg, Foot Pain
Chest, Ribs, Abdominal Pain
Problems Walking
Appetite
Jaw Pain/TMJ
Tendonitis
Concentrating
Bursitis
Impaired
Arthritis
Osteoporosis
Scoliosis
Other: _____

CIRCULATOR/RESPIRATORY

Dizziness
Shortness of Breath
Pneumonia
Asthma
Sinusitis
Other: _____

DIGESTIVE

Ulcers
Colitis
IBS
Crone's Disease
Gluten Intolerance Neuritis
Diarrhea
Constipation
Gallstones
Gas/Bloating
Chronic Indigestion/Reflux

SKIN

Fungal Infections
Athlete's Foot
Impetigo
Eczema/Dermatitis
Easily Irritated Skin
Other: _____

NERVOUS SYSTEM

ALS
MS
Parkinson's Disease
Bell's Palsy

Spinal Cord Injury
Trigeminal Neuralgia
Seizures/Epilepsy

OTHERS

Diabetes
Pregnancy
Cancer
Kidney Disease
Hepatitis
HIV/AIDS
Lupus
Postoperative: _____
Cystitis
High Stress
Grieving
Anxiety/Panic Attacks
Bipolar Syndrome
PMS/Menopause
Poor Sleep/Insomnia
Allergies: _____
Orthopedic Pins or Plates
Other: _____

EXERCISE

Time/Day-Week: _____ Activities: _____

_____

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The above information is accurate. I understand that Massage Therapist do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur***. I also understand that a missed appointment might incur charges that I must pay.***

Signature _____Date _____