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Massage Therapy Intake Form

Welcome! The following information will be used to help plan safe and effective massage sessions.
Please answer all questions to the best of your knowledge. All of your information will be kept confidential.

Name_____ Date of birth_____

Best phone #_____ Email_____

Address_____

Occupation_____ Emergency contact_____

Referred by_____ May I thank them for referring you?_____

May I include you on my monthly email newsletter list (for articles, self care & special offers)?_____

Have you ever received a professional massage?_____ If yes, how often?_____

Do you receive other forms of bodywork (chiropractic, acupuncture, physical therapy, etc.)?_____

Are you currently under a physician's care for an acute or chronic illness/condition? Yes No

If yes, please explain _____

Please list any injuries and/or surgeries:_____

Please list your current medications: _____

Are there specific areas of the body where you're experiencing tension, stiffness, pain or discomfort?

_____

What helps your pain or discomfort?_____

Are there any areas you'd like me to avoid?_____

Are you allergic or sensitive to any essential oils, nuts, fruits, aromas or other food or product ingredients?

_____

What do you do for exercise?_____ How much water do you drink each day? _____

Do you sit or stand for long periods of time or perform any repetitive movement at work, home or school?

_____

Health History—Please mark an 'X' for all current conditions and a 'P' for all past conditions:

____headaches/migraines

____scoliosis

____herniated/bulging disc/pinched nerve

____muscle cramping

____muscle strain/sprain

____bruise easily

____high blood pressure

____low blood pressure/dizziness/fainting spells

____varicose veins or blood clots

____decreased sensation/numbness/tingling

____psoriasis/eczema

____contagious skin condition

____athlete's foot/nail fungus

____anxiety/stress

____recent accident, injury, or surgery

____infectious disease

____arthritis, artificial joint, bursitis, tendonitis, dislocations

____osteoporosis

____TMJ/jaw pain

____carpal tunnel syndrome/tennis elbow

____diabetes

____cancer/radiation/lymph nodes removed/lymphedema

____fibromyalgia/chronic fatigue syndrome

____heart condition/circulatory disorder

____neurological condition/stroke/seizures

____asthma/allergies/sinus issues

____celiac/crohn's/IBS

____depression

____currently pregnant or trying to conceive? If pregnant, how many weeks?_____

Are there any other health issues that I should be aware of to be able to provide a safe and effective massage?

_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort experienced during or after a session. I understand that this is a therapeutic massage and non-sexual in nature. I further 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 that I am aware of. I understand that massage therapists are not qualified to perform 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

Client printed name_____ Date_____

Client signature_____

Therapist signature_____ Date_____