Massage Client Intake

Name _____ Date of Birth _____

❑ Male ❑ Female

Address _____

City _____ State _____ Zip _____

Phone_____Email_____

How did you hear about us? _____

Referred By _____

In Case of Emergency Contact_____

Phone_____ Relationship _____

Are you currently under the care of a Physician? ❑ Yes ❑ No

If yes, name of Physician and reason

_____

Massage Information

Please take a moment to carefully answer the following questions. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral from your primary care provider may be required prior to services being provided.

Have you had a professional massage before?

❑ Yes ❑ No

If yes, how frequently do you get a massage?

_____

_____

If yes, do you have a style or pressure preference?

Specify: ❑ light ❑ medium ❑ firm pressure ❑ Other

What are your common areas of pain or tension?

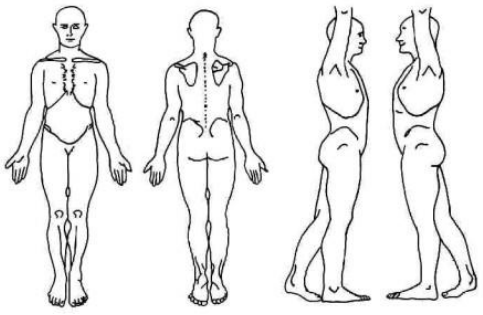
_____

_____

Are you aware of any tension holding spots in your body?

❑ Yes ❑ No

If yes, Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

Please indicate any condition that you have had or currently have:

- ❑ Headaches / Migraines
- ❑ Allergies / Sensitivity
- ❑ Arthritis / Tendonitis
- ❑ Bruise Easily
- ❑ Cancer / Tumors
- ❑ TMJ Problems
- ❑ Abnormal Skin Condition
- ❑ Heart / Circulation Problems
- ❑ Joint Replacement / Surgery
- ❑ High / Low Blood Pressure
- ❑ Major Accident
- ❑ Recent Injuries
- ❑ Lack Of -or- Reduced Feeling / Sensation
- ❑ Varicose Veins
- ❑ Currently Pregnant
- ❑ Blood Clots
- ❑ Epilepsy / Seizures
- ❑ Neck / Back Injuries
- ❑ Diabetes
- ❑ Paralysis
- ❑ Fibromyalgia
- ❑ Numbness
- ❑ Sprains

Explain any condition you have marked above:

_____

Are there any other health concerns you wish to discuss today?

❑ Yes ❑ No If yes, please describe:

_____

_____

Are you currently experiencing any of the following conditions?

❑ Flu or Cold ❑ Inflammation ❑ Fever ❑ Infection ❑ Disease

Do you suffer from chronic or persistent pain/discomfort?

❑ Yes ❑ No If so, for how long?

_____

Do you know what causes/caused it or when the symptoms seem to get worse or better?

_____

Do you see a chiropractor? ❑ Yes ❑ No

If so, how often?

_____

Are you currently under medical care? ❑ Yes ❑ No

Are you currently taking any prescription medication?

❑ Yes ❑ No If so, name meds and reason

_____

_____