Massage Therapy Client Intake

Patient Information

Name: ____ **Date of birth:** ______________________

Address: ____ **City:** _______________________ **State:** ______ **Zip:** ___________

Primary phone: _____________________________ **Secondary phone:** ________________________________

Email address: ____ **Occupation:** _________________________________

Emergency contact: _____________________________ **Phone:** ____________________ **Relationship:** __________________

How were you referred? ______________________ **Have you received a massage before?** ______ **When?** __________

Health Information

Are you currently under a physician's care for an illness? ____ **If so, please explain:** _______________________________

Please list any medications or supplements: ____

What are your goals for massage therapy? ____

Please list any areas of tension or pain that you would like addressed: ____

Please mark an (X) by all current conditions and a (P) by all past conditions

__ Abdominal/digestive problems	__ Allergies	__ Anxiety	__ Arthritis/tendonitis
__ Asthma/lung problems	__ Athlete's foot	__ Blood clots	__ Chronic pain
__ Circulatory/heart problems	__Constipation/diarrhea	__ Depression	__ Diabetes
__ Fatigue	__ Headaches	__ Hearing problems	__ Hernia
__ High blood pressure	__ Jaw pain/TMJ pain	__ Low blood pressure	__ Muscle/bone injuries
__ Muscle/joint pain	__ Numbness/tingling	__ Pregnancy	__ Rash/fungus
__ Sinus problems	__ Sleep difficulties	__ Spinal disorders	__ Sprain/strain
__ Tension/stress	__ Vision problems	__ Varicose veins	__ Other ___________________________

Elaborate on noted areas above: ____

Please list any recent injuries or surgeries: ____

Do you participate in sports, exercise, hobbies, or stress reduction activities? ________ **If so, what are they?**

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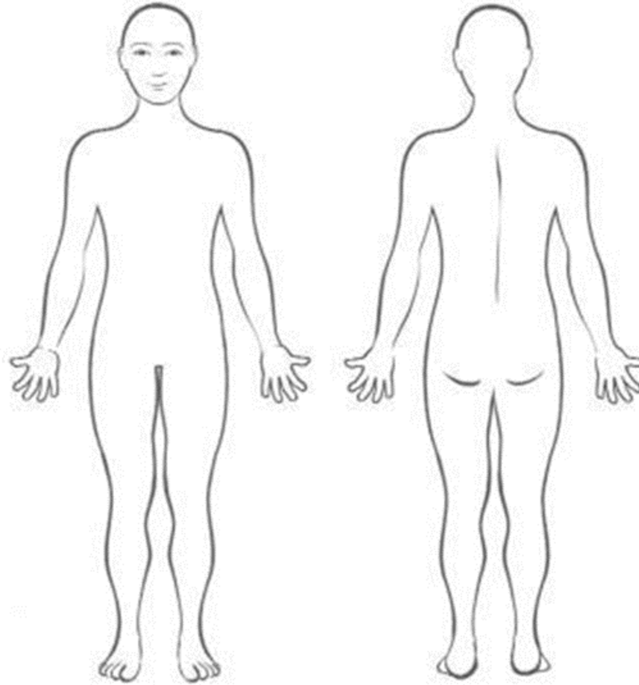
Please mark the areas to identify your symptoms today. Circle the area in roughly the size and shape of your pain/tenderness, numbness/tingling, or joint/muscle stiffness.



I have stated all conditions that I am aware of and this information is true and accurate to the best of my knowledge. I will inform my health care provider and massage therapist if anything changes in my status. I understand that massage therapy I receive is for the purpose of stress reduction and relief of muscular tension, spasm, or pain and to increase circulation. If I experience any pain or discomfort, I will immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level. I understand that my massage therapist does not diagnose illness or disease, nor perform any spinal manipulations, and does not prescribe any medications or treatments. I acknowledge that massage is not a substitute for a medical examination or diagnosis and that I should see my health care provider for those services. If I am unable to attend my scheduled appointment, I will respect and abide by the set cancellation policies. Sexual advances, requests for sexual favors, and any other verbal or physical conduct of a sexual nature will be considered sexual harassment and will not be tolerated. I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in part or in whole, of the aforesaid massage therapy, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Signature: ____ **Date:** __________________