Massage Intake Form

Name _______________________ Phone _______________

Address ____

City/State/Zip Code ________________________________

Email _______________________ Date of Birth ____/____/____

Emergency Contact ___________________ Phone Number __________________

The following information will be used to help your therapist plan a safe and effective massage session.

Please answer the questions to the best of your knowledge.

Have you had a professional massage before? Yes No

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

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

If yes, please explain ______________________________

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

If yes, please explain ______________________________

Do you have sensitive skin? Yes No

What type of pressure do you prefer? Light Medium Deep

Are you wearing: [ ] contact lenses [ ] dentures [ ] hearing aid [ ] prosthetics

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

If yes, please describe ______________________________

Do you perform repetitive movements in your work, sports, or hobby? Yes No

If yes, please explain ______________________________

Are there any areas that you specifically (feet, face, abdomen) that you do **not** want massaged? Yes No

If yes, which areas ______________________________

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

If yes, please explain ____

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Medical History

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

Are you currently under medical supervision? Yes No

If yes, please explain ____

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Are you currently taking any medication? Yes No

If yes, please list: ____

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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 syndrome

( ) carpal tunnel syndrome

( ) tennis elbow

( ) pregnancy If yes, how many months?

Details for any marked above:

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Have you ever been treated for cancer? Yes No

If yes, when were you diagnosed? ___________________

What type of cancer? ____

Where is/was it located? ____

Are you being treated now? Yes No If no, what was the date of your last treatment? __________

Cancer treatment types and dates:____

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Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

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Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _________________________, understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. 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, chiropractor 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 spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said during the session 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 fail to do so.

Signature of client ______________________________ Date _________________________

Signature of Massage Therapist ______________________________ Date ______________