Therapeutic Massage Client Intake Form

Personal Information

Today's Date		
Name	Occupation	
Address		
City	State	ZIP
Phone		Date of Birth
Emergency Contact	Phone	
Physician	Phone	

Massage Information

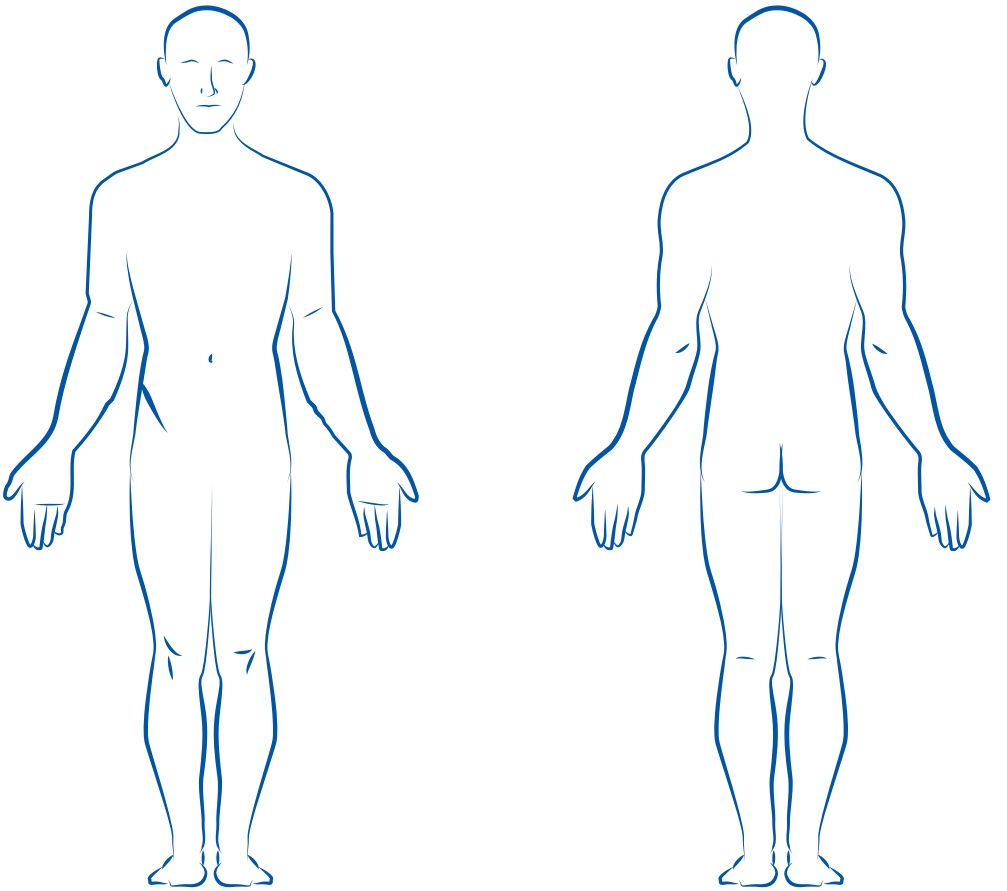
How did you hear about us?	
Have you ever had a professional massage before?	☐ yes ☐ no
If yes, how often do you receive massage therapy?	
Please specify the level of pressure that you prefer.	☐ Light Pressure ☐ Medium Pressure ☐ Deep Pressure ☐ Trigger Point Therapy ☐ Other ☐ No Prefrence
What type of massage are you seeking today?	☐ Relaxation ☐ Deep Tissue/Therapeutic ☐ Myofascial ☐ Bodywork ☐ Medical ☐ Prenatal ☐ Other
What are your common areas of pain or tension?	

Medical History

Are you currently under medical care? ☐ yes ☐ no

If yes, for what condition(s)?			
Are you currently taking any prescription medication(s)? If so, please list and describe.			
Please indicate any conditions that you have had or currently have:			
☐ headaches/migraines	☐ pregnancy	☐ arthritis, tendonitis	☐ allergies/sensitivity
☐ cancer/tumors	☐ abnormal skin condition	☐ heart/circulation problems	☐ TMJ problems
☐ high/low blood pressure	☐ major accident	☐ varicose veins	☐ joint replacement/surgery
☐ blood clots	☐ neck/back injuries	☐ diabetes	☐ paralysis
☐ fibromyalgia	☐ recent injuries	☐ sprains, strains	☐ lack of or reduced feeling/ sensation
Explain any conditions that you have marked above:			

Circle any specific areas you would like the massage therapist to concentrate on during your session



Informed Consent and Massage Policies:

I understand that the massage I will be receiving here is for the purpose of stress reduction, relief of muscular tension or spasm. I understand that the massage therapist does not diagnose illness, disease, or any further physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I understand that massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have.

I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage therapist of any changes to this information. I understand that if I experience any unusual discomfort and/or pain during my massage session it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used.

Privacy Policy: All written records and massage sessions are kept strictly confidential and will not be shared with an outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (me) or the client's legal guardian unless legally required by local, state or federal subpoena, summons or other court order.

Signature _____ Date _____