

Therapeutic Massage — Client Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____
Address _____ City, State, ZIP _____
Email (optional) _____ Date of Birth _____ Occupation _____
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? _____

If yes, do you have a style or pressure preference? yes no

Specify: light pressure medium pressure deep pressure

trigger point therapy energy work

Other _____

What type of massage are you seeking today?

Relaxation Deep Tissue/Therapeutic Pregnancy

Senior Integrated Bodywork (functional)

Other _____

Are you sensitive to fragrances or perfumes? yes no

Do you have sensitive skin? yes no

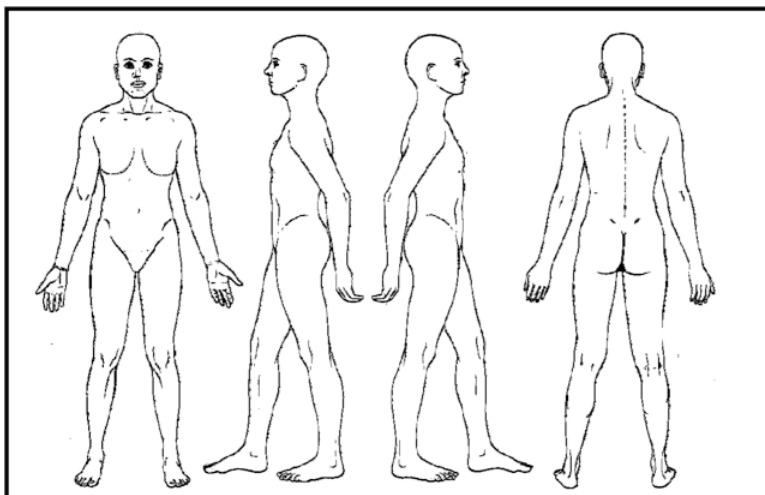
Do you wear contact lenses? yes no

Do you exercise regularly?

If so, what type(s)? _____

What are your common areas of pain or tension?

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



Medical History

Do you suffer from chronic or persistent pain/discomfort?

If so, for how long? _____

Do you know what 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? If so, for what? _____

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

- | | |
|---|---|
| <input type="checkbox"/> headaches, migraines | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> allergies, sensitivity | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> arthritis, tendonitis | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> cancer, tumors | <input type="checkbox"/> neck / back injuries |
| <input type="checkbox"/> TMJ problems | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> abdominal skin condition | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> heart/circulation problems | <input type="checkbox"/> fibromyalgia |
| <input type="checkbox"/> joint replacement / surgery | <input type="checkbox"/> numbness |
| <input type="checkbox"/> high / low blood pressure | <input type="checkbox"/> sprains, strains |
| <input type="checkbox"/> major accident | <input type="checkbox"/> recent injuries |
| <input type="checkbox"/> lack of or reduced feeling / sensation | _____ |

Explain any conditions that you have marked above:

