Client Intake Form

Personal Information

Date of visit

First name

Last name

Birthday

Gender

Email

Phone

Occupation

Referred by

Address

City

State

Zip code

Physician name

Physician phone

Emergency contact

Emergency phone

Reason for Visit

How would you rate your general health?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Excellent

Have you ever had a professional massage?

- ○ No
- ○ Yes

Last time?

Describe injuries, concerns, or issues to address + causes and dates of occurrences

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Describe any treatment you've received for these particular issues

Describe your treatment goals

Health History

Cardiovascular

- [ ] Congestive heart failure
- [ ] Embolism
- [ ] Heart attack
- [ ] Heart disease
- [ ] Hemophilia
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Pacemaker
- [ ] Phlebitis
- [ ] Poor circulation
- [ ] Stroke
- [ ] Thrombosis
- [ ] Varicose veins
- [ ] Family history

Head & Neck

- [ ] Dizziness
- [ ] Ear problems
- [ ] Headaches
- [ ] Hearing loss
- [ ] Jaw pain (TMJ)
- [ ] Migraines
- [ ] Vision loss
- [ ] Vision problems

Musculoskeletal

- [ ] Arthritis
- [ ] Artificial joint
- [ ] Bursitis
- [ ] Osteoporosis
- [ ] Surgical pin/wire
- [ ] Tendonitis

Neurological

- [ ] Epilepsy
- [ ] Multiple sclerosis
- [ ] Numbness/tingling
- [ ] Sensory loss/change
- [ ] Sciatica
- [ ] Seizures

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Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] Chronic cough
- [ ] Emphysema
- [ ] Shortness of breath
- [ ] Sinusitis
- [ ] Smoker
- [ ] Tuberculosis
- [ ] Family history

Reproductive

- [ ] Given birth
- [ ] Gynecological problems
- [ ] Pregnant

Skin

- [ ] Bruise easily
- [ ] Skin conditions
- [ ] Skin infections
- [ ] Skin irritations

Miscellaneous

- [ ] Anxiety
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Digestive conditions
- [ ] Fibromyalgia
- [ ] HIV/AIDS
- [ ] Stress
- [ ] Other

Waiver

Please read and sign:

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that today's services are not a substitute for medical care and that my therapist is not qualified to diagnose, prescribe, or treat physical/mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition and that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I waive and release my therapist from any liability, past, present, and future, relating to massage therapy and bodywork.

Signature _____ Date _____