client intake form

client signature

date of initial visit

personal information

name | date of birth

address

city | state | zip

home phone | cell phone

work phone | ext.

email

occupation

employer

employer address

marital status | if married, spouses name

referred by

emergency contact name (relationship) | emergency contact phone

physician's name | physician's phone

massage experience

Have you had a professional massage before? ❐ Yes ❐ No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?

How long have you been receiving massage therapy? ______________

Frequency of massages? ______________

What are your goals for treatment? ______________

current health

Reason for initial visit ______________

Height & weight ______________

Do you exercise regularly and/or participate in any sports? ❐ Y ❐ N

If yes, what kind of exercise/sports? ______________

Do you perform any repetitive movement in your work, sports or hobby? ❐ Y ❐ N

If yes, describe ______________

Do you sit for long hours at a workstation, computer or driving? ❐ Y ❐ N

If yes, describe ______________

Do you experience stress in your work, family, or other aspect of your life? ❐ Y ❐ N

If yes, describe ______________

Are you experiencing tension, stiffness, discomfort or pain? ❐ Y ❐ N

If yes, describe ______________

Have you recently had an injury, surgery, or areas of inflammation? ❐ Y ❐ N

If yes, describe ______________

Do you have sensitive skin? ❐ Y ❐ N

Do you have any allergies to oils, lotions or ointments? ❐ Y ❐ N

If yes, please explain ______________

List any medications you are currently taking ______________

List any known allergies ______________

health history

Musculoskeletal

___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory

___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory

___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify: ______________
___ Sinus Problems

Nervous System

___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Reproductive

___ Pregnant, stage ______________
___ Ovarian/Menstrual Problems
___ Prostate

Skin

___ Allergies, specify: ______________
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

Digestive

___ Irritable Bowel Syndrome
___ Bladder/Kidney Ailment
___ Colitis
___ Crohn's Disease
___ Ulcers

Psychological

___ Anxiety/Stress Syndrome
___ Depression

Other

___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed: ______________

Please explain any of the conditions that you have marked above : ______________

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