

# MASSAGE CLIENT INTAKE FORM

First Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Phone (cell) \_\_\_\_\_  
Phone (secondary) \_\_\_\_\_  
Email \_\_\_\_\_

Address, City, St, ZIP  
\_\_\_\_\_  
\_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Phone \_\_\_\_\_

**THE FOLLOWING INFORMATION WILL BE USED TO HELP PLAN SAFE AND EFFECTIVE MASSAGE SESSIONS. PLEASE ANSWER ALL THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:**

Primary reason(s) for appointment:  
\_\_\_\_\_  
\_\_\_\_\_

Medical Conditions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all current medications:  
(including aspirin, ibuprofen, herbs, supplements, etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List previous injuries, accidents and surgeries:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any allergies to oils, lotions or ointments? \_\_ YES \_\_ NO  
If Yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a massage? \_\_ YES \_\_ NO  
Was it a positive or negative experience? \_\_\_\_\_

Do you perform any repetitive movement in your work, sports, or hobby? \_\_ YES \_\_ NO  
If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

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

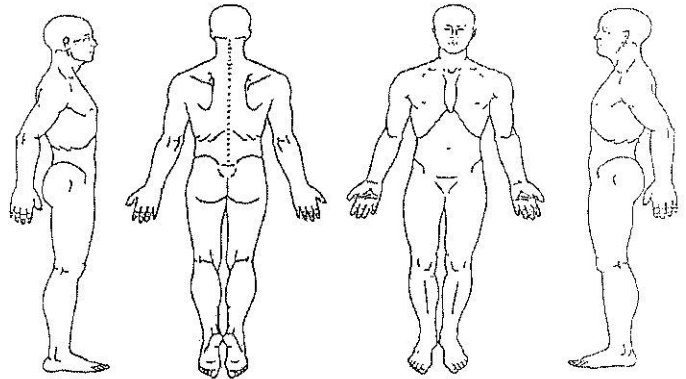
Draping will be used during the session – only the area being worked on will be uncovered.

Please check any conditions listed below that apply to you:

- contagious skin condition
- easy bruising
- joint disorders:  
(rheumatoid arthritis, osteoarthritis, tendonitis)
- recent accident or injury
- recent fracture or sprain
- epilepsy
- recent surgery
- headaches/migraines
- artificial joint
- cancer
- sprains/strains
- diabetes
- current fever
- back/neck problems
- allergies/sensitivity
- fibromyalgia
- heart condition
- high or low blood pressure
- circulatory disorder
- tennis elbow
- varicose veins or deep vein thrombosis/blood clots
- pregnancy – If yes, how many months? \_\_\_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE CIRCLE ANY SPECIFIC AREAS YOU WOULD LIKE THE MASSAGE THERAPIST TO CONCENTRATE ON DURING THIS SESSION**



I have disclosed to the massage practitioner any condition I have that would be contraindicated for massage. Other than to determine contraindications, I understand that no specific needs assessment will be performed. I understand that the massage given here is for the purpose of stress reduction. I understand that massage practitioners do not diagnose illness or disease, perform any spinal manipulations or prescribe any medical treatments. I acknowledge that massage is not a substitute for medical examination or diagnosis and it is recommended that I see a health care provider for those services. I understand that a massage is limited to providing a general, non-specific massage approach using standard massage methods, but does not include any methods to address specifically soft tissue structure or function.

Signature: \_\_\_\_\_  
Date: \_\_\_\_\_