Massage Client History Intake Form

Name _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Email Address _____

Date of Birth _____ Sex: **M** **F** Occupation: _____

Have you had a professional massage before? **N** **Y** If Yes, how long ago? _____

List any medications and purpose: _____

_____

Are there any accidents, major injuries, surgeries or illnesses still affecting you today? **N** **Y**

Please list _____

_____

Are you Pregnant? **N** **Y** If Yes, how many weeks? _____

OB/GYN (if pregnant only) _____ Phone _____

How often do you exercise? _____

What type(s) of exercise? _____

Do you have any allergies? **N** **Y** Please list _____

What is your major area of pain or concern? _____

_____

What would you like to focus on today? _____

_____

Rate your Stress Level: **Low** **Medium** **High**

Type of pressure for your massage: **Light** **Medium** **Firm** **Deep** **Not Sure**

PLEASE CHECK ANY CONDITIONS YOU CURRENTLY HAVE:

☐ Bone/Joint Disease	☐ Arthritis	☐ Blood Clots	☐ Carpal Tunnel Syndrome	☐ Circulatory Problems
☐ Diabetes	☐ Broken Bones	☐ Heart Disease	☐ H/L Blood Pressure	☐ Fibromyalgia
☐ Tendonitis	☐ Bursitis	☐ Gout/Lupus	☐ Plantar Fasciitis	☐ Tennis Elbow
☐ Jaw Pain/TMJ	☐ Osteoporosis	☐ Spinal Problems	☐ Sciatica	☐ Asthma
☐ Varicose Veins	☐ Lymphedema	☐ Thrombosis	☐ Emphysema	☐ Sinus Problems
☐ Shingles	☐ Numbness	☐ Tingling	☐ Nerve Degeneration	☐ Seizures
☐ Pinched Nerve	☐ MS	☐ Cancer	☐ Chronic Fatigue	☐ Chronic Pain
☐ Sleep Disorders	☐ Migraines	☐ Headaches	☐ Dizziness	☐ Anxiety/Stress
☐ Infectious Disease	☐ Emphysema	☐ Rashes	☐ Cold Sores	☐ Inflammation
☐ Digestive Problems	☐ Chest Pain	☐ Abdominal Pain	☐ Other	

Please Describe the Symptoms and or Conditions _____

_____

_____

I understand that massage therapy is for the purpose of relief from muscular tension and spasm, stress reduction, general relaxation and improvement of circulation and energy flow.

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear that massage therapy is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

I have stated all my known medical conditions, and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____ Date _____