# Massage Therapy Client Intake Form

Print Name: _____ Date: _____/_____/_____

Address: _____ Gender: ____ Male ____ Female

City/State: _____ Zip: _____

Email: _____ Cell Phone: _____

Occupation: _____ DOB: _____/_____/_____

Emergency Contact: _____ His/Her Phone: _____

To whom shall we say "Thank You" for referring you to our office? _____

An accurate health history ensures that it is safe for you to receive massage therapy, and helps determine a proper treatment plan. All information is ***confidential***. Indicate all conditions that are current ( **C** ) or had in the past ( **P** ).

___ Accident, Recent
___ Blood Clots
___ Blood Pressure High
___ Blood Pressure Low
___ Cancer
___ Contagious Disease
___ Diabetes
___ Eczema
___ Emphysema
___ Epilepsy
___ Fever, Recent
___ Fractures
___ Head Injury
___ Heart Condition
___ Hepatitis
___ Hernia
___ Herniated Disk
___ Herpes/Shingles
___ Hip Replacement
___ HIV virus
___ Lymph Edema
___ Migraines
___ Numbness
___ Osteoporosis
___ Pacemaker
___ Pinch Nerve
___ Psoriasis
___ Surgery, Recent
___ Stroke
___ Thyroid Hyper
___ Thyroid Hypo
___ Tuberculosis
___ Varicose Veins
___ Whiplash
___ Other
_____

Is this your first massage? _____

If no, when was your last session? _____

Desired pressure: ___ Light ___ Firm ___ Deep

Are you pregnant? _____

If yes, how many weeks? _____

Are you wearing any of the following?

___ Contact Lenses ___ Other Devices

___ Dentures _____

___ Hearing Aid(s) _____

Do you have any difficulty lying on your front, back or side?

_____

List any additional information that the therapist should know:

List any surgeries and injuries (bone breaks/fractures, dislocations, sprains, head/neck/spine injuries, whiplash, vehicle accidents, falls, or other trauma) with approximate dates. _____

_____

List any and all drugs and general supplements: _____

_____

Are you currently seeing a Healthcare Practitioner (chiropractor, physician, alternative practitioner)? _____ If yes, please explain:

_____

1. I understand if I experience any pain or discomfort during my massage therapy session, I will immediately inform the therapist so that the pressure and/or strokes will be adjusted to my level of tolerance.
2. I understand a) that the therapist is not a physician and does not diagnose any physical or mental disorder; b) massage therapy is not a substitute for a medical examination; c) nor will the therapist prescribe pharmaceuticals or perform spinal or skeletal manipulations; d) no assurance or guarantee has been provided to me as to the results of the treatment; and e) that with any treatment, there can be risks and those risks have been explained to me and I assume those risks.
3. I understand the therapist must be made fully aware of my existing medical conditions. I have disclosed all of my medical conditions that I am aware of. I agree to inform the therapist of any changes in my medical profile. I hereby waive and release the therapist from any and all liability, past, present, and future relating to treatment if I fail to do so. The information provided is true and complete to the best of my knowledge.
4. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the scheduled appointment.
5. I affirm my consent to treatment. I understand that at any time, I may withdraw my consent and treatment will end.

► Please sign.

Client: _____ Date: _____

Therapist: _____ Date: _____