Massage Client Intake Form

Personal Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

DOB: _____ Age: _____

Sex: _____ Height: _____ Weight: _____

History

Exercise Frequency: _____ Exercise Type(s): _____

Do you smoke? _____ Have you ever smoked? _____ How Often? _____

How much water do you drink per day? _____

What medications are you currently using? _____

Previous complaints/surgeries/medications: _____

What is your major complaint? _____

Have you received massage therapy before? _____

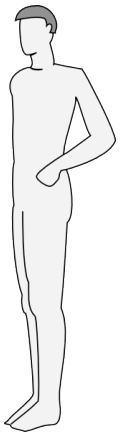
Goals for massage therapy today? ☐ Relaxation ☐ Rehabilitation ☐ High activity level maintenance

Preferred type of touch: ☐ Light/Meditative ☐ Heavy/Invigorating ☐ Deep/Trigger Point

Do You Have Any of the Following Today? (Check All That Apply)

☐ Sunburn	☐ Cuts, Burns, Bruises	☐ Inflammation	☐ Irritated Skin Rash
☐ Headache	☐ Severe Pain	☐ Poison Ivy	☐ Cold or Flu
☐ Asthma	☐ Arteriosclerosis	☐ Pregnancy	☐ Arthritis
☐ Diabetes	☐ Varicose Veins	☐ Hernia	☐ Stomach Ulcers
☐ Epilepsy	☐ Dizziness	☐ Cancer	☐ Pins/Pacemaker
☐ Depression	☐ High Blood Pressure	☐ Contact Lenses	☐ Heart Disease
☐ Hemophilia	☐ Low Blood Pressure	☐ Musculoskeletal Problems	

Mark Areas of Discomfort



I understand that massage is designed for the purpose of relaxation and relief from tension, muscle spasms or poor circulation. The massage therapist cannot diagnose medical issues/diseases/disorders or perform spine palpitations.

_____ _____

Signature Date