



Massage Intake Form

The following information will be kept confidential:

Name: _____ Phone (H) _____ (W) _____ (C) _____

Address: _____ City _____ ST _____ Zip _____

Date of Birth: _____ Age _____ Occupation _____

Email Address: _____

Emergency Contact: _____

1. Have you ever received a professional massage before? Yes No
2. Are you currently under the care of a health care practitioner? If yes, please explain: _____

3. Injuries/accidents/illnesses still affecting you: _____
4. Surgeries: _____
5. Are you pregnant? If yes, how many weeks? _____

Medical Profile

Please mark any of the following that you now have or have had:

Musculoskeletal

- Bone or joint disease Fibromyalgia Tendonitis/Bursitis Lupus
- Arthritis/Gout Jaw Pain (TMJ) Spinal Problems Fractures
- Sprains/Strains Other: _____

Circulatory

- Heart condition Lymphedema Phlebitis/Varicose Veins Blood Clots
- Thrombosis/Embolism High/Low Blood Pressure Other: _____

Respiratory

- Breathing Difficulty/Asthma Sinus Problems Emphysema
- Allergies (specify): _____ Other: _____

Nervous System

- Shingles Pinched Nerve Epilepsy Other: _____

Skin

- Allergies (specify): _____ Rashes Herpes/cold sores
 Athlete's foot Other: _____

Digestive

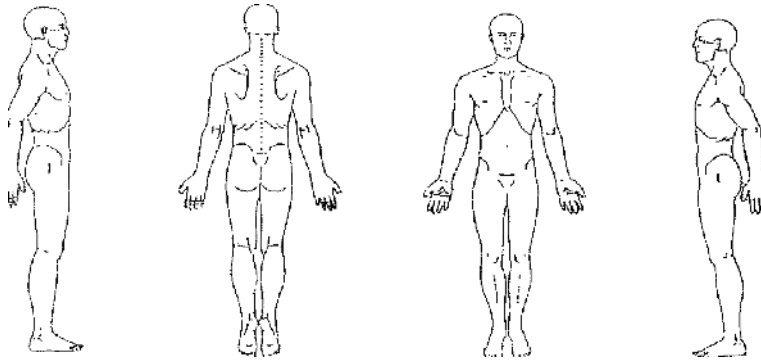
- Irritable bowel syndrome Ulcers Other: _____

Other

- Cancer/tumors Bladder/kidney ailment Diabetes Fever Chronic Pain
 Migraines/headaches Depression Anxiety/stress syndrome

Additional client remarks/comments

Please indicate problem areas below:



Areas to avoid: _____ Areas of emphasis: _____

Clients under the age of 18 require informed written consent from their parent or legal guardian

Please read the following carefully and sign and date:

I _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief from muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted accordingly. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client: _____ Date: _____

Signature of Parent/Legal Guardian (if applicable): _____