

# Therapeutic Massage – Client Intake Form

## Personal Information

Name \_\_\_\_\_ Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Email (optional) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

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

Physician \_\_\_\_\_ Phone \_\_\_\_\_

## Massage Information

How did you hear about us? \_\_\_\_\_

Have you ever had a professional massage before?  yes  no

If yes, how often to you receive massage therapy? \_\_\_\_\_

If yes, do you have a style or pressure preference?  yes  no

Specify :  light pressure  medium pressure  deep pressure

trigger point therapy  energywork

Other \_\_\_\_\_

What Type of massage are you seeking today?

Relaxation  Deep Tissue/Therapeutic  Pregnancy

Senior  Integrated Bodywork (*functional*)

Other \_\_\_\_\_

Are you sensitive to fragrances or perfumes?  yes  no

Do you have sensitive skin?  yes  no

Do you wear contact lenses?  yes  no

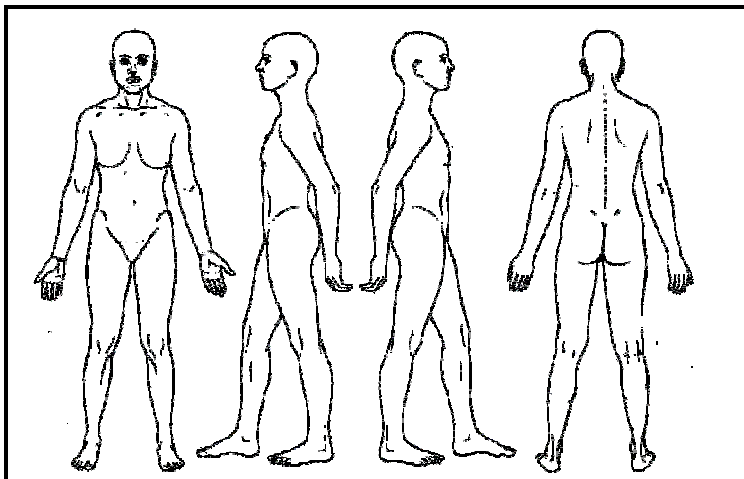
Do you exercise regularly?  yes  no

If so, what type(s)? \_\_\_\_\_

What are your common areas of pain or tension?

\_\_\_\_\_  
\_\_\_\_\_

**Circle any specific areas you would like the massage therapist to concentrate on during the session:**



## Medical History

Do you suffer from chronic or persistent pain/discomfort?

\_\_\_\_\_

If so, for how long? \_\_\_\_\_

Do you know what caused it or when then symptoms seem to get worse or better? \_\_\_\_\_

\_\_\_\_\_

Do you see a chiropractor?  yes  no

If so, how often? \_\_\_\_\_

Are you currently under medical care?  yes  no

Are you currently taking any prescription medication? If so, for what? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please indicate any conditions that you have had or currently have:

headaches, migraines

varicose veins

allergies, sensitivity

pregnancy

arthritis, tendonitis

blood clots

cancer, tumors

neck / back injuries

TMJ problems

diabetes

abnormal skin condition

paralysis

heart/circulation problems

fibromyalgia

joint replacement / surgery

numbness

high / low blood pressure

sprains, strains

major accident

recent injuries

lack of or reduced feeling / sensation \_\_\_\_\_

Explain any conditions that you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_