client intake form

date of initial visit

personal information

name

address

city | state | zip

home phone | cell phone

work phone

email

occupation

marital status

referred by

emergency contact name | emergency contact phone

physician's name | physician's phone

massage experience

Have you had a professional massage before? ☐ Y ☐ N

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?

How long have you been receiving massage therapy? _____

Frequency of massages? _____

What are your goals for treatment? _____

health history

Musculoskeletal
___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw Pain (TMJ)
___ Lupus
___ Spinal Problems
___ Migraines/Headaches
___ Osteoporosis

Circulatory
___ Heart Condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

Respiratory
___ Breathing Difficulty/Asthma
___ Emphysema
___ Allergies, specify: _____
___ Sinus Problems

Nervous System
___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

Reproductive
___ Pregnant, stage _____
___ Ovarian/Menstrual Problems
___ Prostate

current health

Do you exercise regularly and/or participate in any sports? ☐ Y ☐ N
If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? ☐ Y ☐ N
If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? ☐ Y ☐ N
If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? ☐ Y ☐ N
If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? ☐ Y ☐ N
If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? ☐ Y ☐ N
If yes, describe _____

Do you have sensitive skin? ☐ Y ☐ N

Do you have any allergies to oils, lotions or ointments? ☐ Y ☐ N
If yes, please explain _____

List any medications you are currently taking _____

List any known allergies _____

Skin
___ Allergies, specify: _____
___ Rashes
___ Cosmetic Surgery
___ Athlete's Foot
___ Herpes/Cold Sores

Digestive
___ Irritable Bowel Syndrome
___ Bladder/Kidney Ailment
___ Colitis
___ Crohn's Disease
___ Ulcers

Psychological
___ Anxiety/Stress Syndrome
___ Depression

Other
___ Cancer/Tumors
___ Diabetes
___ Drug/Alcohol/Tobacco Use
___ Contact Lenses
___ Dentures
___ Hearing Aids

Any other medical condition(s) not listed: _____

Please explain any of the conditions that you have marked above :