



Massage Intake Form

Personal information

Legal Name _____ Date of birth (required) _____

Nickname (what you'd like to be called) _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Work phone _____ Ext. _____

Email _____ Occupation _____

Employer _____

Employer address _____

Male _____ Female _____ Other: _____
Single _____ Married _____ Partnered _____ Other: _____

Spouse/Partner name _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____

Referred by

Physician's name _____ Physician's phone _____

Massage experience

Have you had a professional massage before? Yes _____
No _____

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? _____

Are there any areas, besides those covered by draping at all times, that you would like me to avoid or not to touch? (Most bathing suit areas will be covered)

Yes _____ No _____ If yes, what areas? _____

Date of initial visit _____

Current health

Reason for initial visit _____

Height _____ Weight _____

Do you exercise or participate in sports? Yes _____ No _____

If yes, what activities and how often? _____

Do you perform any repetitive movement in your work, sports or hobby? Yes _____ No _____

If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? Yes _____ No _____

If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? Yes _____ No _____

If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? Yes _____ No _____

If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? Yes _____ No _____

If yes, describe _____

Do you have sensitive skin? Yes _____ No _____

Do you have any allergies to oils, lotions or ointments? Yes _____ No _____

If yes, explain _____

List any medicines (including herbal) and supplements you take _____

List any known allergies _____

Have you been diagnosed with any conditions? Yes _____
No _____

If yes, what were you diagnosed with? _____

Treated when and by whom (name and type of healthcare provider) _____

Have you had any major injuries or illnesses? Yes _____ No _____
If so, please describe _____



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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

Skin

- ☐ Allergies, specify:
- ☐ Rashes
- ☐ Cosmetic Surgery
- ☐ Athlete's Foot
- ☐ Herpes/Cold Sores
- ☐ Fungus or Athletes foot
- ☐ Recent tattoos or piercings

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 conditions not listed:

Please explain any of the conditions that you marked:

Client Consent

I give consent to receive massage therapy. I am aware of the benefits and risks. I acknowledge that Massage therapy is not a substitute for medical examination or diagnosis, I will inform my practitioner of any changes in my health. I will participate fully in my own self-care program. I agree to communicate with my massage therapist if I have any concerns or questions.

Gluteal Area Massage

The gluteal area can hold a lot of stress and be responsible for many problems in the legs and back. Compressions and stretching in this area can help. This is an area that, by law, is required to have consent to massage.

Do you consent to gluteal massage? Yes No

signature

date

Draping

Massage therapists are required to practice "equal decency" with all clients. I will offer breast draping to male clients and it is required for females.

I acknowledge that this had been explained to me _____

I authorize and direct payment of medical benefits to my massage therapist, for services billed.

signature

date

signature of parent or legal guardian (if client is a minor)

Subscribe to my newsletter for healthy tips?

Yes No

Is it okay to contact you via phone, email or postal?

Yes No



Release of Medical Records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.

Signature

Date

Signature of parent or legal guardian (if client is a minor)

(Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.)