Client Intake Form

Name: _____ Home Phone: _____ Cell #:_____

Address: _____ City: _____ State/Zip: _____

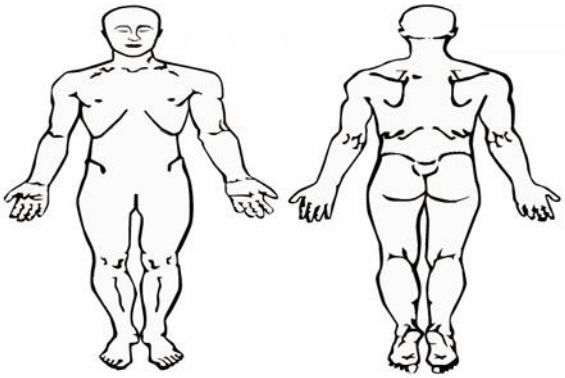
DOB: __/___/_____ Emergency Contact Name: _____ Contact Phone #:_____

Occupation: _____ Have you ever had a massage? YES / NO If Yes, Which Type: _____

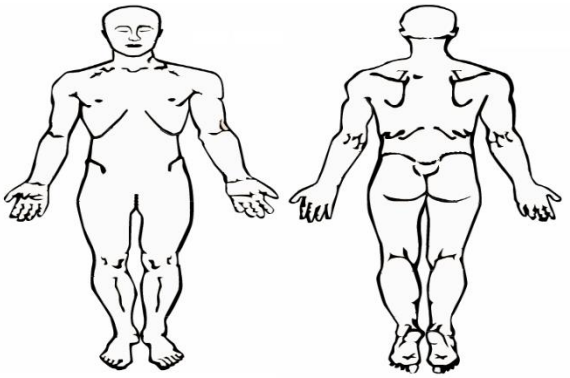
Reason for Visit: ☐ Relaxation ☐ Pain Management ☐ Limited Range of Motion ☐ Other: _____

Email Address (To receive appointment reminders and special offers):_____

Indicate on **DIAGRAM** any areas you want **FOCUSED**



Indicate on **DIAGRAM** any areas you want **AVOIDED**



*Breast massage on female clients is not performed unless specifically requested. *It is standard practice to massage the gluteal region unless otherwise indicated.

PLEASE MARK ALL CURRENT AND PAST CONDITIONS:

☐ Contagious Skin Condition	☐ Open Sores or Wounds	☐ High/Low Blood Pressure	☐ Blood Clots/Deep Vein Thrombosis
☐ Easy Bruising	☐ Recent Accident /Injury	☐ Recent Fracture	☐ Recent Surgery
☐ Joint Replacement	☐ Sprains/Strains	☐ Current Fever/Chills	☐ Swollen Glands
☐ Allergies/Sensitivities	☐ Heart Condition	☐ Pacemaker	☐ Circulatory Disorder
☐ Varicose Veins	☐ Atherosclerosis	☐ Phlebitis	☐ Arthritis/Joint Disorder
☐ Osteoporosis	☐ Epilepsy	☐ Headaches/Migraines	☐ Diabetes
☐ Numbness	☐ Back/Neck Issues	☐ Fibromyalgia	☐ TMJ
☐ Carpel Tunnel	☐ Tennis Elbow	☐ Frozen Shoulder	☐ Pregnant (How many Months? ___)

Please explain any checked conditions listed above and anything else you think your therapist should be aware of: _____

_____

Please list any medications prescribed or you are currently taking: _____

_____

Disclaimer: This place of business will not be held liable for any injury or condition that arises from application of massage despite completion of this form. The form is intended as an assessment tool only and serves as a guide for the application of massage not for medical treatment or medical assessment. Breast Massage on female clients will not be performed unless specifically requested on this form and prior consent given. Clients under the age of 18 must have a parent or legal guardian present to provide a signature for authorization for the therapeutic massage session.

I have stated all conditions that I am aware of and this information I provided is true and accurate to the best of my knowledge. I agree to inform my massage therapist immediately of any change in the conditions stated above. I acknowledge that this information is confidential and intended for review by massage therapists; that a medical referral may be requested of me; and that the place of business is not liable for the management of any condition. If uncomfortable for any reason, a client may end the session. I also understand that any illicit or sexually suggestive remarks or advances may result in immediate termination of the session, and I will be liable for full payment of the appointment.

Client Signature (Parent/Guardian if Minor):_____ Date: _____

Signature of Therapist: _____ Date: _____