Massage Therapy
CLIENT INTAKE FORM

Name	DOB	Date
Address		
City	State	Zip
Email	Occupation	
Emergency Contact	Phone	

Have you ever received massage therapy? Yes ☐ No ☐

Primary reason for appointment today:

_____

Are you taking any medication? Yes ☐ No ☐

List: _____

Are you pregnant? Yes ☐ No ☐

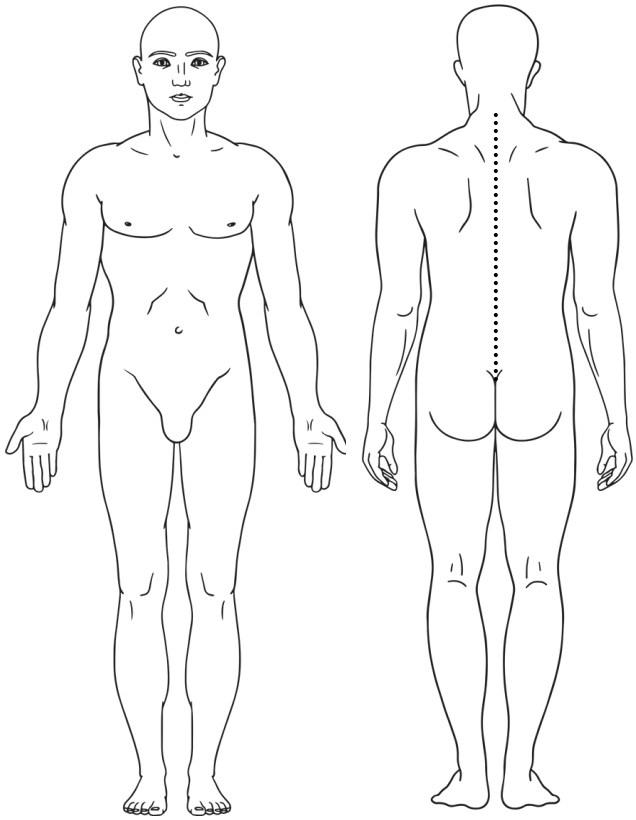
Have you consumed alcohol in the last 24 hours? Yes ☐ No ☐

Have you had any lymph nodes removed? Yes ☐ No ☐

Do you have a history of any of the following?

- ☐ Headaches
- ☐ Vision Problems
- ☐ Contact Lenses
- ☐ Hearing Problems
- ☐ Face/Head Injury
- ☐ Sinus Problems
- ☐ Jaw Pain/TMJ
- ☐ Abdominal Issues
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hernia
- ☐ Fatigue
- ☐ Seizures
- ☐ Tension/Stress
- ☐ Numbness
- ☐ Tingling
- ☐ Muscle Problems
- ☐ Joint Problems
- ☐ Arthritis
- ☐ Tendonitis
- ☐ Sprains/Strains
- ☐ Spinal Problems
- ☐ Athelete's Foot
- ☐ Eczema
- ☐ Blood Clots
- ☐ Varicose Veins
- ☐ Depression
- ☐ Anxiety
- ☐ Smoker
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Breathing Problems
- ☐ Bleeding Problems
- ☐ Infections
- ☐ Diabetes
- ☐ Pain
- ☐ Easy Bruising
- ☐ Rash
- ☐ Allergies
- ☐ Pregnancy
- ☐ Sleep Problems
- ☐ Cancer
- ☐ Mastectomy
- ☐ HIV
- ☐ _____

Please indicate with an (X) the areas you are feeling discomfort:



Please explain/describe areas of concern marked above:

_____

_____

_____

_____

Please read the following and sign below:

- I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. The massage therapist does not prescribe medical treatment nor perfom spinal manipulations. I will inform the therapist of my current condition at the time of each visit.

Signature _____ Date _____