Massage Therapy Client Intake Form

Name _____ Birthday _____
Address _____
City _____ State _____ Zip/Postal Code _____
Phone # _____ Email_____
Occupation _____
Physician's Name _____Physician's Phone # _____
Emergency Contact Name _____ Phone # _____
Would you like to be added to our email list for specials and discounts? ☐Yes ☐No
How did you hear about us? _____

Medical History

Please check all that apply:

☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Bursitis	☐ Bronchitis	☐ Cancer
☐ Chronic cough	☐ Diabetes	☐ Digestive conditions
☐ Emphysema	☐ Epilepsy	☐ Fibromyalgia
☐ Frequent colds	☐ Headaches/migraines	☐ Hearing loss
☐ Heart attack	☐ Heart disease	☐ Hemophilia
☐ Hepatitis	☐ Herpes	☐ HIV/AIDS
☐ High blood pressure	☐ Jaw pain (TMJ)	☐ Low blood pressure
☐ Lyme disease	☐ Multiple sclerosis	☐ Numbness/tingling
☐ Osteoporosis	☐ Pacemaker	☐ Poor circulation
☐ Psychiatric disorder	☐ Rashes	☐ Ringing in ears
☐ Sciatica	☐ Seizures	☐ Sensory loss/change
☐ Shortness of breath	☐ Sinusitis	☐ Smoker
☐ Stroke	☐ Tendonitis	☐ Vertigo/dizziness
☐ Vision loss	☐ Vision problems	☐ Other: _____

How would you rate your general health?
☐Excellent ☐Good ☐Fair ☐Poor

Are you currently under medical care? ☐Yes ☐No
Are you or could you be pregnant? ☐Yes ☐No
Are you currently taking any medications? ☐Yes ☐No
If yes, please explain: _____

Do you have any allergies? ☐Yes ☐No
If yes, please explain: _____

Do you see a chiropractor? ☐Yes ☐No
If yes, how often: _____

Do you suffer from chronic pain? ☐Yes ☐No
If yes, please explain: _____

Do you sit for long periods of time? ☐Yes ☐No
If yes, please explain: _____

Have you had any major accidents or surgeries? ☐Yes ☐No
If yes, please explain: _____
_____

How would you describe your stress level (1 being lowest, 10 being highest):
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Conditions you are currently experiencing today (please select all that apply):
☐ Anxiety ☐ Fatigue ☐ Forgetfulness ☐ Headache
☐ Inflammation ☐ Insomnia ☐ Muscle Cramps ☐ Stress

Additional Information

Have you had a professional massage before? ☐Yes ☐No
If yes, when: _____

Do you have difficulty laying on your front, back, or side? ☐Yes ☐No
If yes, please explain: _____

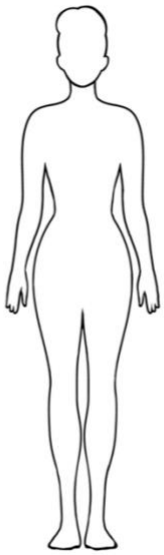
Are you sensitive to touch or pressure on any areas of your body? ☐Yes ☐No
If yes, please explain: _____

Are there areas that you do not want massaged? ☐Yes ☐No
If yes, please explain: _____

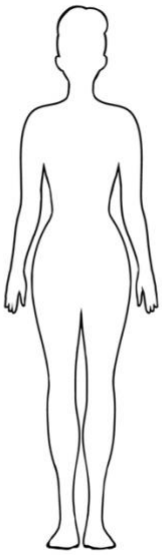
Are you sensitive to fragrances or perfumes?
Do you have sensitive skin? ☐Yes ☐No
Do you wear contact lenses? ☐Yes ☐No
Do you wear dentures? ☐Yes ☐No
Do you wear a hearing aid? ☐Yes ☐No
Do you exercise regularly? ☐Yes ☐No

What pressure level would you like?
☐Light ☐Medium ☐Firm

Circle any specific areas you would like the massage therapist to focus on:



Front



Back

Right

Left

By signing below, I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the massage therapist of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the massage therapist of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my massage therapist and the spa for any injury or damages incurred due to any misrepresentation of my health.

Printed Name _____ Signature _____ Date _____