

Massage Client Intake Form

Personal Information

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
DOB: _____ Age: _____
Sex: _____ Height: _____ Weight: _____

History

Exercise Frequency: _____ Exercise Type(s): _____
Do you smoke? _____ Have you ever smoked? _____ How Often? _____
How much water do you drink per day? _____
What medications are you currently using? _____
Previous complaints/surgeries/medications: _____
What is your major complaint? _____
Have you received massage therapy before? _____
Goals for massage therapy today? Relaxation Rehabilitation High activity level maintenance
Preferred type of touch: Light/Meditative Heavy/Invigorating Deep/Trigger Point

Do You Have Any of the Following Today? (Check All That Apply)

- | | | | |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Sunburn | <input type="checkbox"/> Cuts, Burns, Bruises | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Irritated Skin Rash |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Severe Pain | <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Cold or Flu |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Pms/Painmaker |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Musculoskeletal Problems | |

Mark Areas of Discomfort



I understand that massage is designed for the purpose of relaxation and relief from tension, muscle spasms or poor circulation. The massage therapist cannot diagnose medical issues/diseases/disorders or perform spine palpations.

Signature _____

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Date _____