

## 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 \_\_\_\_\_