Therapeutic Massage – Confidential Client Intake Form

Personal Information

Name: _____ Phone (____) _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Occupation: _____ ○ Male ○ Female

Emergency Contact: _____ Phone (____) _____ Physician: _____

Massage Information

How did you hear about us? _____

Have you ever had professional massage before? ○ Yes ○ No How recently? _____

What kind of pressure do you prefer? ○ Light ○ Medium ○ Firm

What type of massage are you seeking today? ○ Relaxation ○ Deep Tissue/Therapeutic ○ Pregnancy

○ Sports ○ Energy Work ○ Integrated Bodywork ○ Other _____

Are you sensitive to fragrances or perfumes? ○ Yes ○ No

If yes, what? _____

Do you have sensitive skin? ○ Yes ○ No

Do you wear contact lenses? ○ Yes ○ No

Do you exercise regularly? ○ Yes ○ No

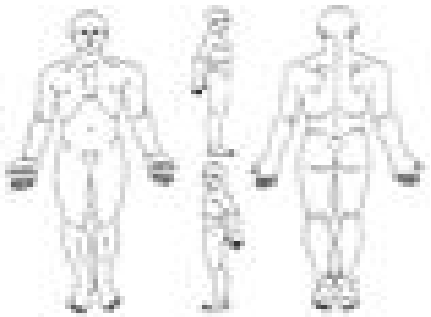
If so, what type(s)? _____

_____

What are your common areas of pain or tension?

_____

_____



Please use the body diagrams to the right to indicate any areas you would like the massage therapist to concentrate on.

Medical History

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Do you suffer from chronic or persistent pain/discomfort? _____ If so, for how long? _____

Do you know what caused it/what makes the symptoms better or worse? _____

Do you see a chiropractor? ○ Yes ○ No If so, how often? _____

Are you currently under medical care? ○ Yes ○ No