UNC | FITNESS AND WELLNESS

Client Intake Form – Massage Therapy

Personal Information

Name: _____ Date: _____

DOB/Age: _____

Campus/Current Information

Phone: _____ Email: _____

University Affiliation (please circle one): Faculty Staff Student Other_____

Preferred Method of Communication: Phone Text Email Other_____

Emergency Contact Information

Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit: _____

Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? _____

Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain: _____

Do you have any allergies to oils, lotions, or ointments? Yes No

If yes, please explain: _____

Do you have sensitive skin? Yes No

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe: _____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe: _____

Do you experience stress in your work, family, or other aspect of your life? Yes No

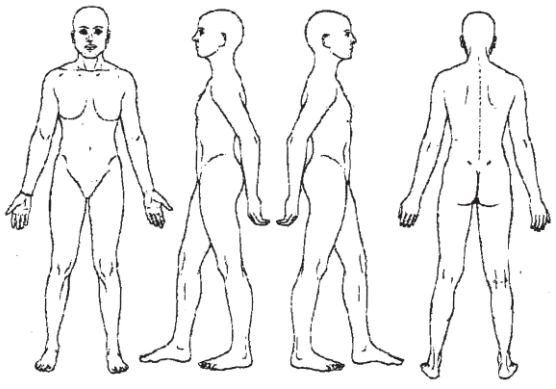
If yes, how do you think it has affected your health?

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other: _____

Primary reason for today's appointment/areas of pain, tension, and/or discomfort?

_____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

Please list current medications, including aspirin, herbs, supplements, etc.:

_____

Smoking status: ☐Never Smoked ☐Used to Smoke ☐Currently Smoke*

*Packs per day (amount):_____ *Number of years smoked:_____

If you quit smoking, when did you quit?: _____

Do you currently use cigars, pipes, or smokeless tobacco products? Yes No

List all surgeries: _____

List all accidents/injuries: _____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

Please mark **(X)** for all conditions that apply:

☐ headaches, migraines	☐ chronic pain	☐ fatigue
☐ vision problems, contact lenses	☐ muscle or joint pain	☐ tension or stress
☐ hearing problems, deafness	☐ fibromyalgia	☐ depression
☐ injuries to face or head	☐ carpal tunnel	☐ sleep difficulties
☐ sinus problems	☐ numbness or tingling	☐ rashes or athlete's foot
☐ dental bridges, braces	☐ muscle sprains or strains	☐ any known infectious disease
☐ jaw pain, TMJ problems	☐ abdominal/digestive problems	☐ problems with blood clots
☐ asthma or lung problems	☐ arthritis, tendonitis, bursitis	☐ heart or circulatory problems
☐ allergies or other sensitivities	☐ spinal problems or disorders	☐ diabetes
☐ constipation or diarrhea	☐ pregnancy	☐ high or low blood pressure
☐ hernia	☐ birth control/IUD	☐ cancer, tumors or growths

☐ other medical conditions not listed: _____

Explain any areas noted above:_____

_____

_____

The above stated information is true and accurate to the best of your knowledge.

Client Signature: _____ Date: _____

Massage Therapist Signature: _____ Date: _____