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: ________________