# Massage & Bodywork Therapy Service Intake Form

**Personal Information**

Name _____Phone _____

Address _____ City/State/Zip _____

Occupation _____ Employer _____

Email _____ Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

---

**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 _____

1. Have you had a professional massage before? YES NO

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

2. Do you have any difficulty lying on your front, back, or side? YES NO

   If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? YES NO

   If yes, please explain _____

4. Do you have sensitive skin? YES NO

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? YES NO

   If yes, please describe _____

7. Do you perform repetitive movement in your work, sports, or hobbies? YES NO

   If yes, please describe _____

8. 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 _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? YES NO

   If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? YES NO

    If yes, please explain _____

---

**Medical History**

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

11. Are you currently under medical supervision? YES NO

    If yes, please explain _____

12. Do you see a chiropractor? YES NO If yes, how often? _____

13. Are you currently taking any medication? YES NO

    If yes, please list _____

14. Please check any condition listed below that applies to you:

| | |
|---|---|
| ( ) contagious skin condition | ( ) phlebitis |
| ( ) open sores or wounds | ( ) deep vein thrombosis/blood clots |
| ( ) easy bruising | ( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| ( ) recent accident or injury | ( ) osteoporosis |
| ( ) recent fracture | ( ) epilepsy |
| ( ) recent surgery | ( ) headaches/migraines |
| ( ) artificial joint | ( ) cancer |
| ( ) sprains/strains | ( ) diabetes |
| ( ) current fever | ( ) decreased sensation |
| ( ) swollen glands | ( ) back/neck problems |
| ( ) allergies/sensitivity | ( ) fibromyalgia |
| ( ) heart condition | ( ) TMJ |
| ( ) high or low blood pressure | ( ) carpal tunnel syndrome |
| ( ) circulatory disorder | ( ) tennis elbow |
| ( ) varicose veins | ( ) pregnancy If yes, how many months? |
| ( ) atherosclerosis | |

Please explain any condition that you have marked above

_____

_____

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

_____

_____

Draping will be used during the session – only the area being worked on will be uncovered.

A typical massage consists of work on the feet, legs, hands, arms, abdomen, back, shoulders, neck, face, and scalp. Is there any area of the body you would not like to be worked on?

_____

I, _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature _____ Date _____

Therapist Signature _____ Date _____