

Massage Therapy Client Intake

Please complete this form before your session and review the acknowledgments on page 3.

Personal Information

First name _____ Last name _____

Date of birth _____ Gender _____

Occupation _____

Email _____ Phone _____

Address _____

City _____ State _____ ZIP _____

Physician name _____ Physician phone _____

Emergency contact _____ Emergency phone _____

Referred by _____

Reason for Visit

Is this your first professional massage: ☐ No ☐ Yes Last session: _____

Describe injuries, concerns, or issues to address, including causes and dates.

Describe any treatment you have received for these issues.

What are your goals for this session?

Health History

Client name _____ Date _____

Check all that apply. Use the space below to provide details about checked items.

Cardiovascular

- | | | |
|---|---|--|
| ☐ Congestive heart failure | ☐ Embolism | ☐ Heart attack |
| ☐ Heart disease | ☐ Hemophilia | ☐ High blood pressure |
| ☐ Low blood pressure | ☐ Pacemaker | ☐ Phlebitis |
| ☐ Poor circulation | ☐ Stroke | ☐ Thrombosis |
| ☐ Varicose veins | ☐ Family history | |

Head and Neck

- | | | |
|---------------------------------------|--|------------------------------------|
| ☐ Dizziness | ☐ Ear problems | ☐ Headaches |
| ☐ Hearing loss | ☐ Jaw pain (TMJ) | ☐ Migraines |
| ☐ Vision loss | ☐ Vision problems | |

Musculoskeletal

- | | | |
|---------------------------------------|--|-------------------------------------|
| ☐ Arthritis | ☐ Artificial joint | ☐ Bursitis |
| ☐ Osteoporosis | ☐ Surgical pin/wire | ☐ Tendonitis |

Neurological

- | | | |
|--|---|--|
| ☐ Epilepsy | ☐ Multiple sclerosis | ☐ Numbness/tingling |
| ☐ Sensory loss/change | ☐ Sciatica | ☐ Seizures |

Respiratory

- | | | |
|------------------------------------|--|---|
| ☐ Asthma | ☐ Bronchitis | ☐ Chronic cough |
| ☐ Emphysema | ☐ Shortness of breath | ☐ Sinusitis |
| ☐ Smoker | ☐ Tuberculosis | ☐ Family history |

Reproductive

- | | | |
|--------------------------------------|---|-----------------------------------|
| ☐ Given birth | ☐ Gynecological problems | ☐ Pregnant |
|--------------------------------------|---|-----------------------------------|

Skin

- | | | |
|---|--|--|
| ☐ Bruise easily | ☐ Skin conditions | ☐ Skin infections |
| ☐ Skin irritations | | |

Miscellaneous

- | | | |
|-----------------------------------|---|---------------------------------------|
| ☐ Anxiety | ☐ Cancer | ☐ Depression |
| ☐ Diabetes | ☐ Digestive conditions | ☐ Fibromyalgia |
| ☐ HIV/AIDS | ☐ Stress | ☐ Other |

Please provide relevant details, including any other conditions or injuries.

Client Acknowledgments

Client name _____ Date _____

Waiver

Please read and sign below.

- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/technique can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that today's services are not a substitute for medical care and that my therapist is not qualified to diagnose, prescribe, or treat physical/mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition and that there shall be no liability on the therapist's part should I forget to do so.

Client signature _____ Date _____

Cupping Acknowledgment

I understand that cupping may be offered as an optional technique during my massage session. Cupping may cause temporary redness, marks, or skin discoloration in treated areas, which may remain visible for several days. Individual responses may vary.

I understand that completing this acknowledgment does not mean I am required to receive cupping. Cupping will only be performed with my consent, and I may decline or ask that it be stopped at any time.

☐ I have read and understand the information above.

Client signature _____ Date _____