

# Massage and Bodywork Intake Form

## Client Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Street \_\_\_\_\_ Day Phone (    ) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Eve Phone (    ) \_\_\_\_\_  
Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Emergency Contact Name and Phone \_\_\_\_\_ (    ) \_\_\_\_\_  
Referred By \_\_\_\_\_ Email \_\_\_\_\_

## Massage History / Session Information

Have you ever received a professional massage?  Yes  No    Date of last massage \_\_\_\_\_  
What result do you want from your massage sessions? \_\_\_\_\_  
List any exercise activities. Include frequency: \_\_\_\_\_  
\_\_\_\_\_

Are you currently under the care of a health care practitioner?  Yes  No  
If yes, specify purpose: \_\_\_\_\_

List current medications and purpose: \_\_\_\_\_  
\_\_\_\_\_

## Previous History (Include year and treatment received)

Injuries/accidents/illnesses still affecting you: \_\_\_\_\_  
\_\_\_\_\_

Surgeries: \_\_\_\_\_  
\_\_\_\_\_

## Please mark any of the following that you now have or have had.

### Musculoskeletal

- Bone or joint disease
- Tendonitis / Bursitis
- Arthritis / Gout
- Jaw pain (TMJ)
- Lupus
- Spinal Problems
- Other : \_\_\_\_\_

### Circulatory

- Heart Condition
- Phlebitis / Varicose Veins
- Blood Clots
- High / Low Blood Pressure
- Lymphedema
- Thrombosis / Embolism
- Other : \_\_\_\_\_

Please mark any of the following that you now have or have had. (Continued)

Respiratory

- Breathing difficulty / Asthma
- Emphysema
- Allergies specify: \_\_\_\_\_
- Sinus Problems
- Other : \_\_\_\_\_

Nervous System

- Shingles
- Numbness / tingling
- Pinched Nerve
- Other : \_\_\_\_\_

Reproductive

- Pregnant: Stage
- Ovarian / menstrual problems
- Prostate
- Other : \_\_\_\_\_

Additional Client Remarks / Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Skin

- Allergies specify: \_\_\_\_\_
- Rashes
- Athletes foot
- Herpes / cold sores
- Other : \_\_\_\_\_

Digestive

- Irritable bowel syndrome
- Ulcers
- Other : \_\_\_\_\_

Other

- Cancer / tumors
- Bladder / kidney ailment
- Diabetes
- Drug / alcohol / caffeine / tobacco use
- Chronic fatigue
- Chronic pain
- Sleep disorders
- Migraines / headaches
- Anxiety / stress syndrome
- Depression
- Contact lenses ( hard or soft )

I have completed this form to the best of my knowledge and will inform the massage therapist of any change in my physical health.

I understand that a massage therapist can not diagnose illness, disease, or any other medical, physical, or emotional disorder, nor perform any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailments that I have.

I understand that massage therapy is a therapeutic health aide and is non-sexual.

I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.

I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

Signed \_\_\_\_\_ Date \_\_\_\_\_