

Client Intake Form



Personal Information

Date of visit _____

First name _____

Last name _____

Birthday _____

Gender _____

Email _____

Phone _____

Occupation _____

Referred by _____

Address _____

City _____

State _____

Zip code _____

Physician name _____

Physician phone _____

Emergency contact _____

Emergency phone _____

Reason for Visit

How would you rate your general health?

- Poor Fair
 Good Excellent

Have you ever had a professional massage?

- No
 Yes Last time? _____

Describe injuries, concerns, or issues to address + causes and dates of occurrences

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Describe injuries, concerns, or issues to address + causes and dates of occurrences

Describe your treatment goals

Health History

Cardiovascular

- | | | |
|---|---|--|
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Embolism | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thrombosis |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Family history | |

Head & Neck

- | | | |
|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Jaw pain (TMJ) | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Vision loss | <input type="checkbox"/> Vision problems | |

Musculoskeletal

- | | | |
|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Surgical pin/wire | <input type="checkbox"/> Tendonitis |

Neurological

- | | | |
|--|---|--|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Sensory loss/change | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Seizures |

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Respiratory

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Family history |

Reproductive

- | | | |
|--------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Given birth | <input type="checkbox"/> Gynecological problems | <input type="checkbox"/> Pregnant |
|--------------------------------------|---|-----------------------------------|

Skin

- | | | |
|---|--|--|
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Skin infections |
| <input type="checkbox"/> Skin irritations | | |

Miscellaneous

- | | | |
|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive conditions | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stress | <input type="checkbox"/> Other |
-

Waiver

Please read and sign:

- 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/strokes 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.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I waive and release my therapist from any liability, past, present, and future, relating to massage therapy and bodywork.

Signature _____

Date _____