

**Client Intake Form**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had a professional massage before? Frequency?

2. Do you have any pain or difficulty lying on your front, back, or side?

3. Allergies to oils—lotions? nuts? latex? essential oils? fragrances? other?

4. Are you wearing contact lenses, dentures, hearing aids? Do you have any prosthetics, pacemaker, port, hardware (rod, ball/socket, plate, etc.)

4. Do you sit for long hours at a workstation, computer, or in a vehicle?

5. Do you perform repetitive movement in your work, sports, or hobby?

6. How is your stress level? How do you feel stress in your work, family, or other aspect of your life affects you? (*circle all that apply*): \_\_muscle tension \_\_\_anxiety \_\_\_insomnia \_\_ irritability \_\_\_other *(specify):*

7. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? You may indicate it on the following chart and/or in words.



 *front* *back*

8. Is there anything that makes the pain better?

 worse?

9. Are you under medical supervision of an MD? A chiropractor? Physical Therapist? Massage Therapist? If so, who?

10. List current medications, vitamins, minerals, herbal supplements, essential oils you’re taking and what they are treating:

11. How often do you use alcohol, recreational drugs, tobacco, sodas? List kind and frequency.

12. Have you ever lived in an abusive situation at home or work? Experienced physical violence (child abuse, mugging, rape, etc.)? Or emotional abuse?

**Note any current or past medical conditions and note with a C or P (current or past**

|  |  |
| --- | --- |
| **Integumentary:**\_\_\_\_\_Boils\_\_\_\_\_Fungal infections\_\_\_\_\_Skin cancer\_\_\_\_\_Eczema \_\_\_\_\_Psoriasis\_\_\_\_\_Herpes\_\_\_\_\_Rash\_\_\_\_\_Other**Musculoskeletal:**\_\_\_\_\_Fibromyalgia \_\_\_\_\_Rheumatoid arthritis \_\_\_\_\_Osteoarthritis \_\_\_\_\_Tendonitis\_\_\_\_\_Bursitis\_\_\_\_\_Osteopenia/Osteoporosis\_\_\_\_\_Headaches\_\_\_\_\_Scoliosis \_\_\_\_\_Whiplash\_\_\_\_\_Carpal Tunnel\_\_\_\_\_Strains/sprains \_\_\_\_\_Plantar fasciitis \_\_\_\_\_Concussion \_\_\_\_\_Flat feet or high arch\_\_\_\_\_Tennis/golf elbow\_\_\_\_\_Artificial joint(s)\_\_\_\_\_Rotator cuff injury\_\_\_\_\_Rib fracture/injury\_\_\_\_\_Fracture within past year\_\_\_\_\_Other**Nervous:**\_\_\_\_\_Decreased sensation\_\_\_\_\_Learning disability\_\_\_\_\_Autism spectrum\_\_\_\_\_Seizure disorder\_\_\_\_\_Multiple Sclerosis\_\_\_\_\_Migraine Headaches\_\_\_\_\_Mood disorder (depression/bi-polar)\_\_\_\_\_Stroke**Other:**\_\_\_\_\_Cancer\_\_\_\_\_Diabetes\_\_\_\_\_Hypoglycemia\_\_\_\_\_HIV/AIDS\_\_\_\_\_Thyroid\_\_\_\_\_Pituitary\_\_\_\_\_TMJ Dysfunction\_\_\_\_\_Tinnitus\_\_\_\_\_Pressure behind eyes\_\_\_\_\_Jaw locks open\_\_\_\_\_Jaw pops | **Digestive:**\_\_\_\_\_Cirrhosis\_\_\_\_\_Ulcers\_\_\_\_\_Diverticulitis\_\_\_\_\_Hepatitis\_\_\_\_\_GERD\_\_\_\_\_Hernia\_\_\_\_\_Irritable bowel syndrome\_\_\_\_\_Crohn’s disease\_\_\_\_\_Kidney stones\_\_\_\_\_Gall stones \_\_\_\_\_Troublesome constipation/diarrhea\_\_\_\_\_Other**Respiratory:**\_\_\_\_\_Asthma \_\_\_\_\_Emphysema\_\_\_\_\_Sinusitis\_\_\_\_\_Tuberculosis \_\_\_\_\_COPD \_\_\_\_\_Chronic ear infections\_\_\_\_\_Respiratory infections \_\_\_\_\_Allergies**Circulatory:** \_\_\_\_\_Anemia\_\_\_\_\_Heart disease\_\_\_\_\_Blood pressure high or low\_\_\_\_\_Varicose veins\_\_\_\_\_Clotting disorder\_\_\_\_\_High cholesterol\_\_\_\_\_Bruise easily\_\_\_\_\_Swollen feet\_\_\_\_\_Reynaud’s syndromeReproductive:\_\_\_\_\_Breast cancer\_\_\_\_\_Lactation problems\_\_\_\_\_Prostate cancer\_\_\_\_\_Endometriosis\_\_\_\_\_Ovarian cysts\_\_\_\_\_PMS\_\_\_\_\_Peri- or Menopausal\_\_\_\_\_Pregnant? if C--how many months? if P—how many times?\_\_\_\_\_How many births? |

List accidents--car, falls (on ice, down stairs, etc.), sports injuries, blows to head, childhood incidents (bike wrecks, sledding accidents, falling out of a tree, etc.)

List all surgeries, including dental surgeries (continue on back, if needed)

Please note any other information you feel your therapist needs to know or that will be helpful

in treating you.

In the unlikely event of an emergency, please list two emergency contacts with names and numbers.

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 and completely, to the best of my knowledge. I agree to keep the therapist updated as to any changes in my medical profile, and I release the therapist of any liability if I fail to do so.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed Date

**INFORMED CONSENT FOR MASSAGE THERAPY TREATMENT**

I understand that the massage services are intended to promote relaxation and circulation and to relieve stress, muscle tension, spasms, and related pain. I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any physical ailment that I am aware of. I further understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such.

I understand that my therapist cannot guarantee exactly how my body will respond to any treatment.

If I experience any pain or discomfort during massage sessions, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that any illicit or sexually suggestive remarks or advances will result in immediate termination of the session and that I will nonetheless be responsible to pay for the whole time scheduled. Police may be summoned and charges pressed.

I understand that the therapist reserves the right to refuse to perform massage on anyone whom she deems to have a condition for which massage is contraindicated. This includes a communicable disease, a fever, and the recent use of alcohol or recreational drugs.

If I have a cold or feel like I’m getting sick, I will cancel the session in as timely a manner as possible.

I understand that all information and anything said in my session will be kept confidential, although I also understand that, as medical providers, massage therapists are required by law to report any evidence of abuse of those under others’ care. Adults who are free to leave abusive situations will receive utmost confidentiality and care.

I understand that I have the right to know and should ask about any treatments I am receiving. I may withdraw my consent at any time and treatment will be stopped or modified with my consent.

By signing this form, I consent to being treated with massage therapy, including such assessments, examinations and techniques that may be recommended by my therapist.

I have read this consent form and have had the opportunity to question its contents.

Client Name(Printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LMT signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_