

# client intake form

client signature \_\_\_\_\_

## personal information

name \_\_\_\_\_

address \_\_\_\_\_

city \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

home phone \_\_\_\_\_ cell phone \_\_\_\_\_

work phone \_\_\_\_\_

email \_\_\_\_\_

occupation \_\_\_\_\_

marital status \_\_\_\_\_

referred by \_\_\_\_\_

emergency contact name \_\_\_\_\_ emergency contact phone \_\_\_\_\_

physician's name \_\_\_\_\_ physician's phone \_\_\_\_\_

## massage experience

Have you had a professional massage before?  Yes  No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?  
\_\_\_\_\_

How long have you been receiving massage therapy? \_\_\_\_\_

Frequency of massages? \_\_\_\_\_

What are your goals for treatment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## health history

### Musculoskeletal

- Bone or joint disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw Pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches
- Osteoporosis

### Circulatory

- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

### Respiratory

- Breathing Difficulty/Asthma
- Emphysema
- Allergies, specify: \_\_\_\_\_
- Sinus Problems

### Nervous System

- Shingles
- Numbness/Tingling
- Pinched Nerve
- Chronic Pain
- Paralysis
- Multiple Sclerosis
- Parkinson's Disease

### Reproductive

- Pregnant, stage \_\_\_\_\_
- Ovarian/Menstrual Problems
- Prostate

date of initial visit \_\_\_\_\_

## current health

Do you exercise regularly and/or participate in any sports?  Y  N  
If yes, what kind of exercise/sports? \_\_\_\_\_

Do you perform any repetitive movement in your work, sports or hobby?  Y  N  
If yes, describe \_\_\_\_\_

Do you sit for long hours at a workstation, computer or driving?  Y  N  
If yes, describe \_\_\_\_\_

Do you experience stress in your work, family, or other aspect of your life?  Y  N  
If yes, describe \_\_\_\_\_

Are you experiencing tension, stiffness, discomfort or pain?  Y  N  
If yes, describe \_\_\_\_\_

Have you recently had an injury, surgery, or areas of inflammation?  Y  N  
If yes, describe \_\_\_\_\_

Do you have sensitive skin?  Y  N

Do you have any allergies to oils, lotions or ointments?  Y  N  
If yes, please explain \_\_\_\_\_

List any medications you are currently taking \_\_\_\_\_

List any known allergies \_\_\_\_\_

### Skin

- Allergies, specify: \_\_\_\_\_
- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold Sores

### Digestive

- Irritable Bowel Syndrome
- Bladder/Kidney Ailment
- Colitis
- Crohn's Disease
- Ulcers

### Psychological

- Anxiety/Stress Syndrome
- Depression

### Other

- Cancer/Tumors
- Diabetes
- Drug/Alcohol/Tobacco Use
- Contact Lenses
- Dentures
- Hearing Aids

Any other medical condition(s) not listed: \_\_\_\_\_

Please explain any of the conditions that you have marked above : \_\_\_\_\_

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