

**Client Intake Form for Massage Therapy (Confidential – For Practitioner’s Use Only)**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

E-mail Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_ Hgt \_\_\_\_\_ Wgt \_\_\_\_\_

Referred by \_\_\_\_\_ Emergency Contact and Phone # \_\_\_\_\_

Have you had massage therapy before? Please circle Yes or No  
Are you currently under a physician’s care? Please circle Yes or No  
What are your goals for the session today? \_\_\_\_\_

**Please circle any of the following conditions or problems areas and add any additional information in the space below:**

- |                    |                             |                         |
|--------------------|-----------------------------|-------------------------|
| Allergies          | Depression                  | Phlebitis/Blood Clots   |
| Arthritis          | Diabetes                    | Pins/Pacemaker          |
| Anemia             | Digestive Problem           | Pregnancy               |
| Anxiety            | Dizziness/Fainting          | Psychiatric Disorders   |
| Asthma             | Endocrine Issues            | Recent Surgery          |
| Athlete’s Foot     | Fatigue/Fibromyalgia        | Respiratory Disorders   |
| Bleeding/Bruising  | Headaches/Migraines         | Seizures/Epilepsy       |
| Blood Pressure H/L | Hepatitis                   | Sinus Problems          |
| Bursitis           | Hernia                      | Skin Conditions         |
| Cancer             | Joint Problems              | Smoker                  |
| Cardiac Issues     | Kidney/Urinary/Bladder .    | Stress                  |
| Circulatory Issues | Liver/Gall Bladder/Neuritis | Ulcers                  |
| Contact Lenses     | Muscle Strain/Sprain        | Varicose Veins          |
| Contagious Disease | Osteoporosis                | Vertebral/Disc Problems |

Additional Information or other conditions \_\_\_\_\_

Certain medical conditions and symptoms may be contraindicated for massage therapy, thereby requiring a release from a physician BEFORE receiving treatment. I affirm that I have stated all my known medical conditions and answered all the questions honestly. I will inform the practitioner of all changes in my medical profile. I understand that the sessions are NOT substitutes for medical examination, diagnosis or any other treatments by qualified medical personnel. Massage practitioners are NOT qualified to perform skeletal adjustments or treat mental or physical illnesses and nothing said in the course of treatment should be construed as such. If I experience any discomfort during the session, I will immediately inform the practitioner. It is also understood that any illicit or sexually suggestive remarks or advances will result in IMMEDIATE TERMINATION of the session with payment expected.

I have read and understood the information provided and freely elect to have the practitioner work with me.

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