

**MESSAGE CLIENT INTAKE FORM**

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ City, ZIP \_\_\_\_\_

Phone: Daytime \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

Birth Date \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred By \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_

Physician: \_\_\_\_\_ Phone \_\_\_\_\_

**Message Information**

Is this your first professional massage:      Yes    No

If no, how frequently do you have massage? \_\_\_\_\_

<b>CHECK ALL THAT APPLY</b>		Heart Trouble	
Allergies to oil or lotion		High Blood Pressure	
Arthritis		Low Blood Pressure	
Bursitis		Migraine Headaches	
Cancer		Phlebitis	
Diabetes		Varicose Veins	
Epilepsy		Skin Disorder	
Infectious Disease		Tense Muscle	
Impetigo			
<b>BODY PARTS TO BE MASSAGED</b>			
Head		Arms	
Back		Face	
Buttock		Hands	
Legs		Abdomen	
Shoulders		Upper Chest	
Feet		Neck	

Have you had any recent surgeries?    Yes    No

Are you currently pregnant?    Yes    No

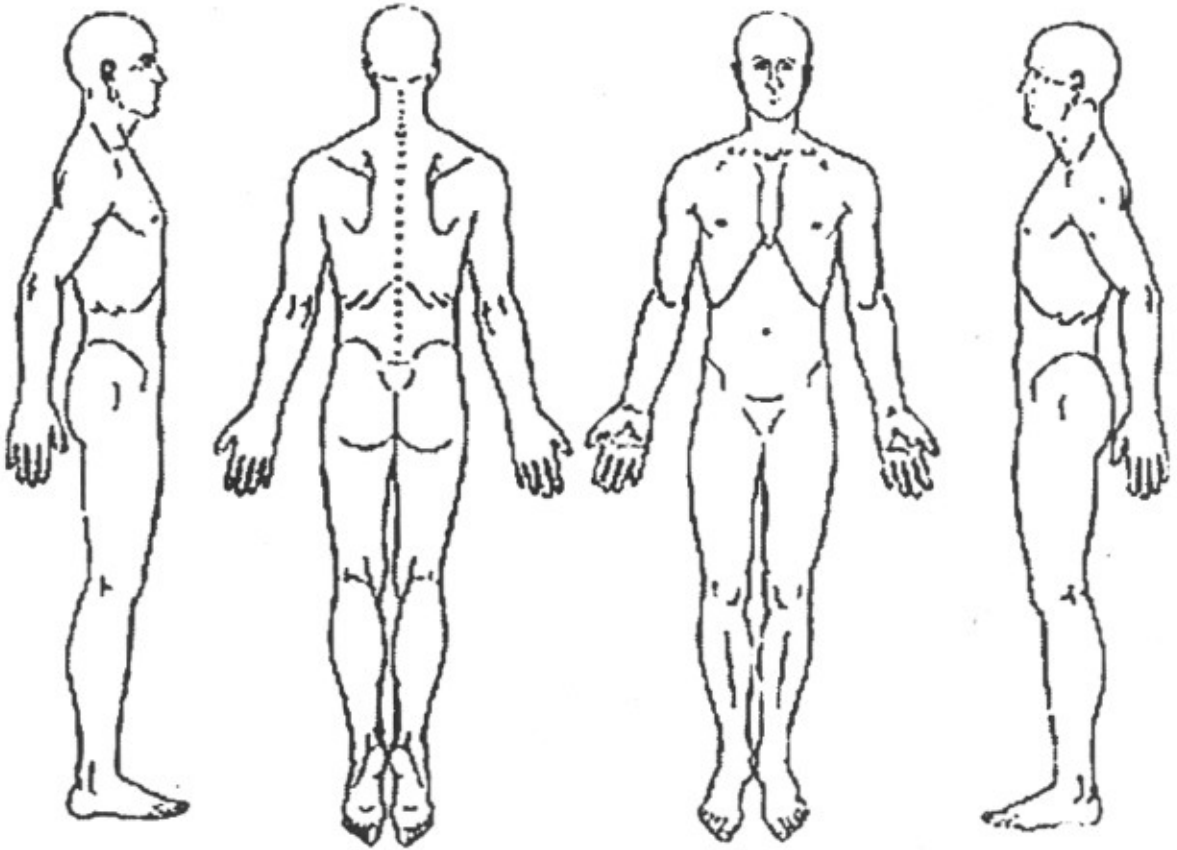
Have you had any recent trauma or injury?    Yes    No

Areas of complaint, pain or tension: \_\_\_\_\_

Areas you wish to be avoided: \_\_\_\_\_

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

On the following, please indicate the problem areas and the sensation: Pain, Numbness, Tingling, Stiffness, etc.



Currently, are you experiencing any of the following conditions:

- Cold or Flu                       Fever
- Contagious Disease: \_\_\_\_\_
- Infection: \_\_\_\_\_
- Open Wounds/Sores: \_\_\_\_\_
- Inflammation: \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please initial the following:

I am responsible for any valuable items I bring into the massage room with me. \_\_\_\_\_

Breast massage will not be performed on female clients without prior consent. \_\_\_\_\_

Proper draping procedures are required to protect the modesty of the client and the therapist. \_\_\_\_\_

If I am uncomfortable for any reason, I may request to end the session. \_\_\_\_\_

I, \_\_\_\_\_, understand that the massage given is for stress reduction and increased circulation and is not to be used in the place of medical treatment. It is recommended I seek a physician for any medical problems that I may have. To the best of my knowledge, all of the information regarding my state of health and medical history is correct. I also understand that a missed appointment might incur charges that I must pay.

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

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_