



MASSAGE CLINIC INTAKE FORM

To maximize the effectiveness of your massage session, please carefully fill out this form. All information will be treated confidentially. Your comfort and safety are our primary concern.

Personal Information

Name: _____ Age: _____ Date: _____

Address: _____

City/State/Zip: _____ Phone: _____

Email address: _____

Occupation: _____

Hobbies/physical activities: _____

How did you find out about the clinic? _____

Primary health care provider:

Person to contact in case of an emergency:

Name: _____

Name: _____

Phone: _____

Phone: _____

Massage History Information

Have you received a professional massage before? Yes No If Yes, what type? _____

How long ago _____ how often: _____ what is your preference? _____

Depth of massage pressure preferred Light Moderate Firm Deep

Do you have difficulty lying on your Back Stomach Right Side Left Side

What are your expectations from massage? _____

Medical History

Do you have or have you ever had any of the following:

Current	Previous	Condition	Current	Previous	Condition
<input type="checkbox"/>	<input type="checkbox"/>	*Allergies: _____	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion/ diarrhea/ constipation
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis - Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis - Rheumatoid	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/ nervousness / stress
<input type="checkbox"/>	<input type="checkbox"/>	Asthma / respiratory conditions	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps/ spasms
<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots / Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/ tingling
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/ tumors	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Sinus conditions
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems/ rashes
<input type="checkbox"/>	<input type="checkbox"/>	Disc problems	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints
<input type="checkbox"/>	<input type="checkbox"/>	Earache/ ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins/ poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	Headaches			
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis		Other	_____

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Are you pregnant or could you be pregnant? Yes No
 Are you currently under the care of a health practitioner? Yes No
 If yes, please explain: _____

Please list current prescriptions and over the counter medications and your associated condition:

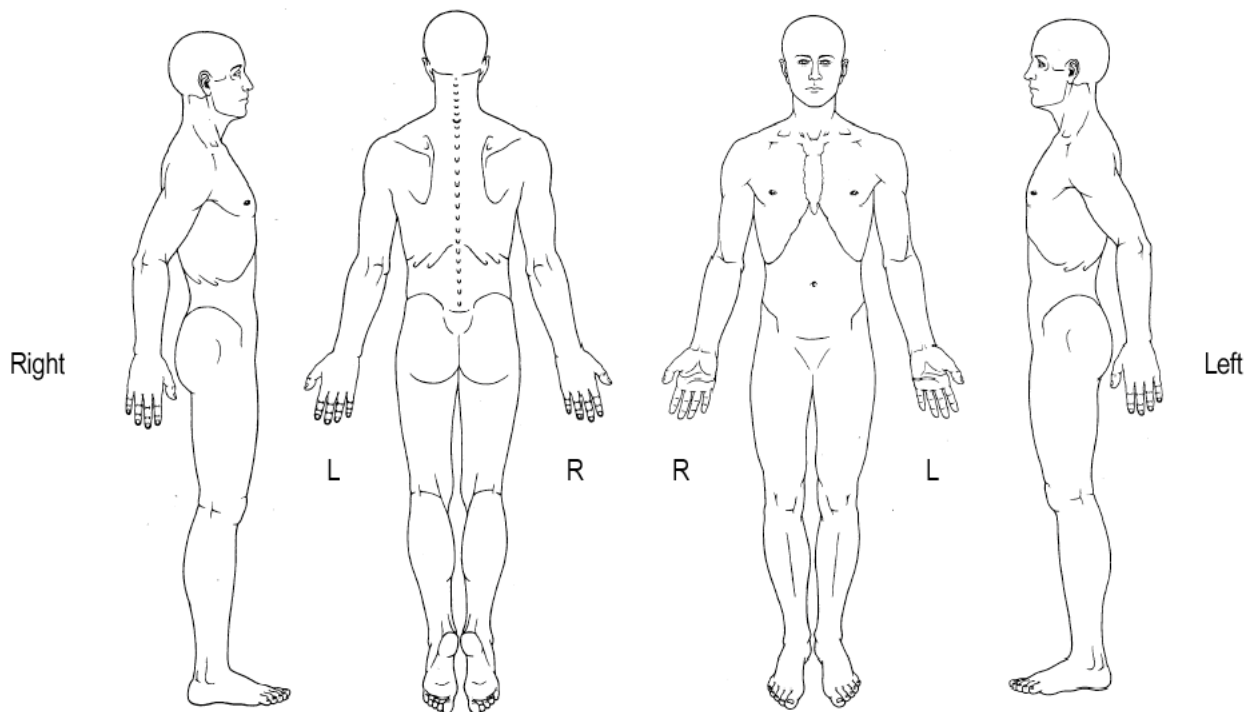
Any heart condition? _____ Blood Pressure: Low Normal High

Have you been hospitalized or had surgery within the past 2 years? Yes No
 If yes, please explain: _____

Have you had any recent injury, serious illness, or are you suffering from a chronic condition? Yes No
 If yes, please explain: _____

Are you wearing any of the following: hard contact lenses hearing aid pacemaker

Please indicate on the diagrams the area(s) where you are experiencing muscle and/or bodily discomfort and/or pain:



Which areas require extra focus? _____
 Which areas would you like avoided? _____

The undersigned stipulates the following:

- I understand that the intent of this program is to help students further their education and abilities in the art and science of massage therapy.
- I am solely responsible for my physical condition and for seeking medical treatment when necessary.
- I acknowledge that the intent of the massage is not to diagnose or treat illnesses.
- I further authorize the College to contact my primary health care provider for information pertaining to my health and safety regarding massage.
- I have read, or had read to me, the above information and to the best of my knowledge certify it to be true.
- I have received, read, and understood the *Massage Clinic Agreement* and agree to abide by its terms and conditions.

*** Please check the massage lotion ingredients for potential allergens.**

Signature: _____

Date: _____