# 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: ______________________________ Date: ______________

Address: ______________________________ Cell #: ______________

City / State / Zip: ______________________________ Age: __________

Email Address: ______________________________

Occupation: ______________________________

Hobbies / Physical Activities: ______________________________

Primary Health Care Provider:

Name: ______________________________

Phone: ______________________________

Person to Contact in Case of an Emergency:

Name: ______________________________

Phone: ______________________________

## Massage History Information

Have you received a professional massage before? ❑ **Y** / ❑ **N**

If yes, what type? ______________________ How long ago? ______________________

Depth of massage pressure preferred ❑ Light ❑ Moderate ❑ Firm

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

What are your goals for this massage? ______________________________

## Medical History

**Do you now have (current) or have you ever had (previous) any of the following:**

| Current / Previous | Condition | Current / Previous | Condition | Current / Previous | Condition |
|---|---|---|---|---|---|
| ❑ / ❑ | Allergies:__________ | ❑ / ❑ | Dizziness | ❑ / ❑ | Numbness/ tingling |
| ❑ / ❑ | Arthritis - Osteoarthritis | ❑ / ❑ | Fatigue | ❑ / ❑ | Osteoporosis |
| ❑ / ❑ | Arthritis - Rheumatoid | ❑ / ❑ | Fibromyalgia | ❑ / ❑ | PMS (Premenstrual) |
| ❑ / ❑ | Asthma / Respiratory | ❑ / ❑ | Foot problem | ❑ / ❑ | Pacemaker / defibrillation |
| ❑ / ❑ | Back pain | ❑ / ❑ | Headaches | ❑ / ❑ | Poor posture |
| ❑ / ❑ | Blood clots / Phlebitis | ❑ / ❑ | Heart disease | ❑ / ❑ | Rashes |
| ❑ / ❑ | Blood pressure: high / low | ❑ / ❑ | Hernia: ____________ | ❑ / ❑ | Skin problem: |
| ❑ / ❑ | Bruise easily | ❑ / ❑ | Immune system problems | ❑ / ❑ | Stroke |
| ❑ / ❑ | Cancer / tumors | ❑ / ❑ | Headaches | ❑ / ❑ | Scoliosis |
| ❑ / ❑ | Cold / Flu | ❑ / ❑ | Hepatitis | ❑ / ❑ | Sinus conditions |
| ❑ / ❑ | Chest pain | ❑ / ❑ | Insomnia | ❑ / ❑ | Tendonitis |
| ❑ / ❑ | Depression | ❑ / ❑ | Irritability / stress | ❑ / ❑ | Tremors |
| ❑ / ❑ | Diabetes | ❑ / ❑ | Lymph node removal | ❑ / ❑ | Varicose veins |
| ❑ / ❑ | Diarrhea / constipation | ❑ / ❑ | Muscle cramps / spasms | ❑ / ❑ | Vertigo |
| ❑ / ❑ | Disc problems | ❑ / ❑ | Neck Pain | ❑ / ❑ | Other: |

Are you pregnant or could you be pregnant? ❑ **Y** / ❑ **N**

Are you currently under the care of a health practitioner? ❑ **Y** / ❑ **N**

**If yes**, please explain: ___________________________________________________________

Please list current medications (write “none” if applicable):

_______________________________________________________________________________

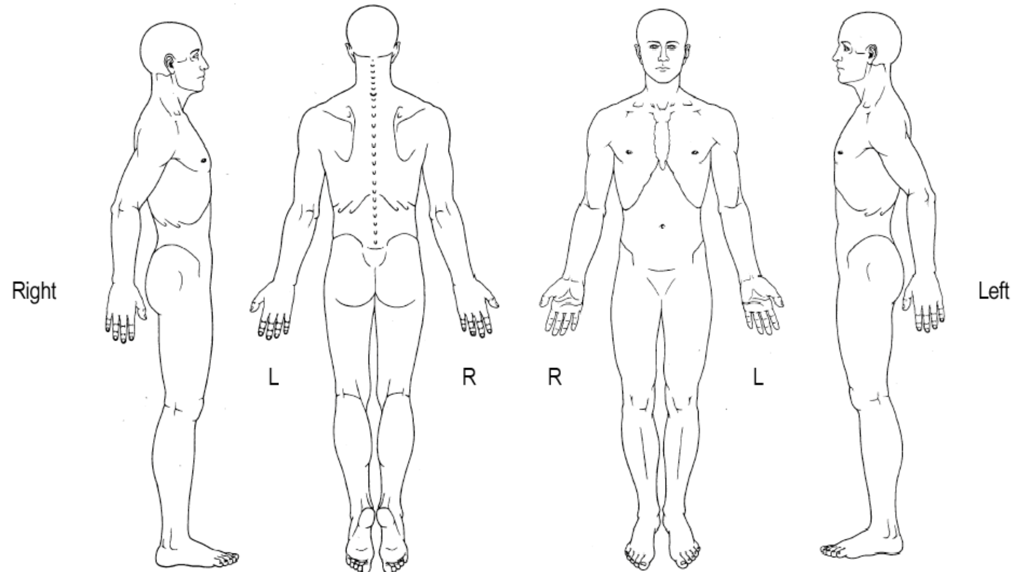
Have you been hospitalized or had surgery within the past 2 years? ☐ **Y** / ☐ **N**

**If yes**, please explain: ___________________________________________________________

Have you had any recent injury or serious illness? ☐ **Y** / ☐ **N**

**If yes**, please explain: ___________________________________________________________

Please circle the area(s) on the diagrams below 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 agrees to 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.**
- 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. I agree to keep the therapist updated as to ANY changes in my medical profile and understand that there shall be no liability on the therapist’s part should I fail to do so.
- I have received, read, and understood the *Massage Clinic Agreement* and agree to abide by its terms and conditions.

Signature:_______________________________________________ Date: ____________________