Massage Clinic Intake Form

De Anza College

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: _____

City/State/Zip: _____ Phone: _____

Email: _____ Date of Birth: _____

Occupation: _____

Hobbies / Physical Activities: _____

Primary Health Care Provider:

Name: _____

Phone: _____

Emergency Contact:

Name: _____

Phone: _____

Massage History Information

Have you received a professional massage before? ☐ Yes ☐ No

If yes, what type? _____ How long ago? _____ How often? _____

Do you have trouble lying on your: ☐ Back ☐ Front ☐ Right Side ☐ Left Side

What are your goals for this massage? _____

_____

Medical History

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Do you have any allergies to oil, lotion or ointment ingredients? ☐ Yes ☐ No

If yes, please explain: _____

Do you experience stress in your work, family or other aspect of your life? ☐ Yes ☐ No

If yes, how do you think it has affected your health?

Muscle Tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other _____

Are you currently under medical supervision? ☐ Yes ☐ No If yes, explain: _____

Please list current medications:

_____

Have you been in an accident or a bad fall? ☐ Yes ☐ No If yes, when? _____

(Please turn over and finish next two pages.)

Please check if you have (current) or have had (previous) any of the following:

Current/Previous

( ) ( ) Arthritis
( ) ( ) Back Pain
( ) ( ) Neck Pain
( ) ( ) Bone or Joint Problems
( ) ( ) Broken/ Fractured Bones
( ) ( ) Headaches
( ) ( ) Jaw Pain/ TMJ
( ) ( ) Scoliosis
( ) ( ) Strains/Sprains
( ) ( ) Tendonitis
( ) ( ) Muscle Cramps/ Spasms

( ) ( ) Blood Clots
( ) ( ) Heart Disease
( ) ( ) Pacemaker
( ) ( ) Hypertension
( ) ( ) Blood Pressure – Low☐ High ☐
( ) ( ) Stroke
( ) ( ) Swollen Feet/ Ankle
( ) ( ) Varicose Veins
( ) ( ) Other: _____

Have you had any lymph nodes removed? ☐ Yes ☐ No
If yes, please explain: _____

( ) ( ) **Cancer**
If yes, please explain _____

_____

Current/Previous

( ) ( ) Allergies
( ) ( ) Athlete's Foot
( ) ( ) Rash

( ) ( ) Asthma
( ) ( ) Sinus Problems

( ) ( ) Constipation
( ) ( ) Diarrhea
( ) ( ) Indigestion
( ) ( ) Gas/ Bloating

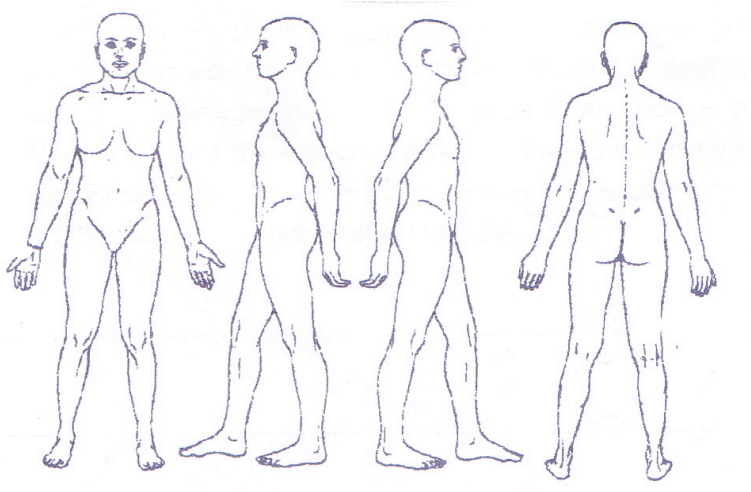
( ) ( ) PMS
( ) ( ) Menopause
( ) ( ) Pregnancy

( ) ( ) Easy Bruising
( ) ( ) Diabetes
( ) ( ) Fatigue
( ) ( ) Fibromyalgia
( ) ( ) Numbness/ Tingling
( ) ( ) Sleeping Problems
If yes, please explain: _____

( ) ( ) **Surgery**
If yes, please explain _____

_____

On the diagram to the below, please circle the specific areas you would like the massage therapist to work on. If there are any areas that you would like the therapist avoid, please mark them with an X.



I, _____ (print name) 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.
- Massage Therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness.

Please Initial

_____ I have received, understood and signed the Massage Clinic Agreement.

_____ 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.

Signature of Client: _____ Date: _____

Signature of Massage Therapist: _____ Date: _____