

# Client Intake Form – Therapeutic Massage

## Personal Information:

Name \_\_\_\_\_ Phone (Day) \_\_\_\_\_ Phone (Eve) \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

email \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

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

**The following information will be used to help plan safe and effective massage sessions.**

**Please answer the questions to the best of your knowledge.**

Date of Initial Visit \_\_\_\_\_

1. Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? \_\_\_\_\_

2. Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain \_\_\_\_\_

3. Do you have any allergies to oils, lotions, or ointments? Yes No

If yes, please explain \_\_\_\_\_

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe \_\_\_\_\_

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe \_\_\_\_\_

8. 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 \_\_\_\_\_

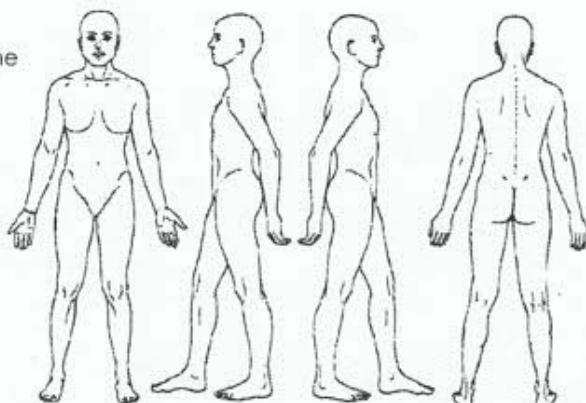
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please identify \_\_\_\_\_

10. Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain \_\_\_\_\_

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Continued on page 2