Your Wellness Sources
6305 Ivy Lane, Suite 101
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CLIENT INTAKE FORM: MASSAGE THERAPY

NAME: _____ **D.O.B.**_____ Sex: ☐ M ☐ F

ADDRESS: _____**CITY**_____ STATE_____ ZIP CODE: _____

PHONE: _____ **EMAIL:** _____

Primary Care Provider □Yes □No Name _____ PHONE #_____

Drug Allergies/Other Allergies: □ Yes □ No If yes, Name & Type of Reaction: _____

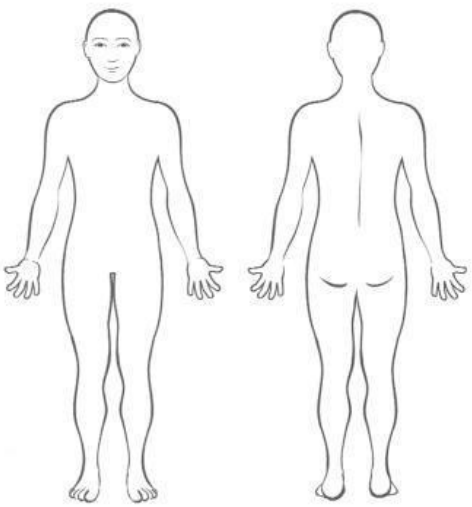
_____

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 □Yes □No ( ) 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 have 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:



MEDICAL HISTORY

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? □Yes □No

If yes, please explain _____

12. Do you see a chiropractor? □Yes □No

If yes, how often? _____

13. Are you currently taking any medication? □Yes □ No

If yes, please list _____

14. **Please check any condition listed below that applies to you.**

( ) contagious skin condition	( ) swollen glands	( ) deep vein thrombosis/blood clots
( ) open sores or wounds	( ) allergies/sensitivity	( ) joint disorder/rheumatoid
( ) easy bruising	( ) heart condition	arthritis/osteoarthritis/tendonitis
( ) recent accident or injury	( ) high or low blood pressure	( ) osteoporosis
( ) recent fracture	( ) circulatory disorder	( ) epilepsy
( ) recent surgery	( ) varicose veins	( ) headaches/migraines
( ) artificial joint	( ) atherosclerosis	( ) decreased sensation
( ) sprains/strains	( ) phlebitis	( ) back/neck problems
( ) current fever	( ) cancer	( ) carpal tunnel syndrome
( ) Fibromyalgia	( ) diabetes	( ) tennis elbow
( ) TMJ		( ) pregnancy If yes, how many months?

*Please explain any condition that you have marked above*_____

_____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? □Yes □No _____

Draping will be used during the session – only the area being worked on will be uncovered.

I, (print name) _____understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. 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**

Client Repeat Visits: _____ _____ /_____ _____ / _____ _____/ _____ _____/ _____ _____

Initials Date Initials Date Initials Date Initials Date Initials Date