Client Intake Form – Therapeutic Massage

Associated Bodywork & Massage Professionals
MEMBER

Name _____ Date of Birth _____ Occupation _____

Address _____ Cell Phone _____

City/State/Zip _____ Alt. Phone _____

Email _____ Referred by _____

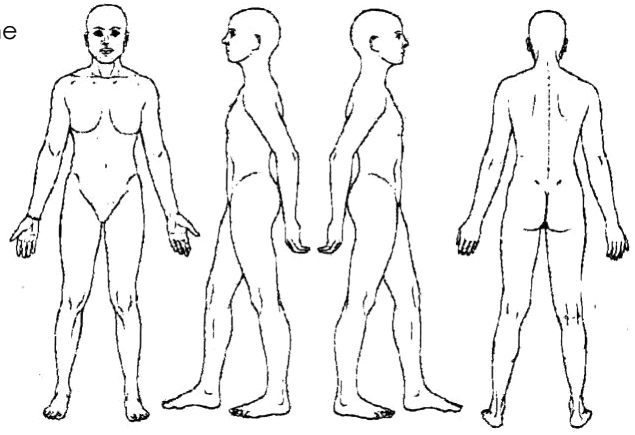
Emergency Contact _____ Phone _____

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

Date of first appointment ____/____/____

1. Have you had a therapeutic massage before? Yes No
   If yes, when did you last 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. Do you wear: contact lenses ( ) dentures ( ) hearing aids ( ) ? (Check all that apply)
6. Do you sit for long hours at a workstation, computer, or while driving? Yes No
   If yes, please describe _____
7. Do any movements or positions cause you pain, discomfort or difficulty with mobility? Yes No
   If yes, please describe _____
   What improves this? _____
8. Do you experience stress in any aspect of your life that you feel is negatively impacting your health? Yes No
   If yes, is it resulting in: muscle tension ( ) headaches ( ) anxiety ( ) insomnia ( ) other _____
9. Are there particular areas of the body where you are experiencing pain, tension or other discomfort? Yes No
   If yes, please identify _____
10. Are there any areas of the body you do NOT want massaged? Yes No
    If yes, please identify _____

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



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11. Are you currently under medical supervision? Yes No

If yes, please explain _____

12. Are you currently taking any medication? Yes No

If yes, please list _____

13. Are you currently pregnant? Yes No

If yes, how many months? _____

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

( ) contagious skin condition	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( ) respiratory disease If yes, please describe:
( ) recent accident or injury	( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis/tendonosis
( ) recent sprains/strains	( ) osteoporosis
( ) recent fracture	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer
( ) current fever	( ) diabetes
( ) swollen glands	( ) decreased sensation
( ) allergies/sensitivity	( ) back/neck problems
( ) heart condition	( ) fibromyalgia
( ) high or low blood pressure	( ) TMJ
( ) circulatory disorder	( ) carpal tunnel syndrome
( ) varicose veins	( ) tennis elbow/golfer's elbow (epicondylitis)
( ) atherosclerosis	( ) other please explain _____

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? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 18 must be accompanied by a parent or legal guardian during the entire session.
Informed written consent must be provided by parent or legal guardian for any client under the age of 18.

I 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 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 ____/____/____