



**Client Intake**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: Home: \_\_\_\_\_ Alternate: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Referred By: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Emergency Contact and Phone: \_\_\_\_\_

**HISTORY/TREATMENT INFORMATION**

Have you ever had a massage? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, what is your previous experience with massage?

What is your primary reason(s) for this visit?

**BACKGROUND**

**Please checkmark all conditions you currently experience, or write (P) for past conditions or (F) for family history.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> allergies/sensitivities | <input type="checkbox"/> headaches/head injuries    | <input type="checkbox"/> rashes/athlete's foot    |
| <input type="checkbox"/> arthritis/tendonitis    | <input type="checkbox"/> hearing problems           | <input type="checkbox"/> recent injuries/illness  |
| <input type="checkbox"/> asthma/lung condition   | <input type="checkbox"/> heart/circulatory problems | <input type="checkbox"/> sinus problems           |
| <input type="checkbox"/> back pain               | <input type="checkbox"/> infectious disease         | <input type="checkbox"/> sleep difficulties       |
| <input type="checkbox"/> blood clots             | <input type="checkbox"/> jaw pain/TMJ disorder      | <input type="checkbox"/> spinal column disorder   |
| <input type="checkbox"/> blood pressure          | <input type="checkbox"/> muscle/bone injuries       | <input type="checkbox"/> sprains/strains          |
| <input type="checkbox"/> cancer/tumors           | <input type="checkbox"/> muscle/joint pain          | <input type="checkbox"/> tension/stress           |
| <input type="checkbox"/> diabetes                | <input type="checkbox"/> neck or shoulder pain      | <input type="checkbox"/> varicose veins/phlebitis |
| <input type="checkbox"/> digestive disorders     | <input type="checkbox"/> numbness/tingling          | <input type="checkbox"/> vision problems/contacts |
| <input type="checkbox"/> fatigue/depression      | <input type="checkbox"/> pregnancy                  | <input type="checkbox"/> other conditions         |

If necessary, please explain any areas noted above:

Please list all medications/supplements you are taking and reason:

Please list any accidents, surgeries, major illnesses with date and description:

I understand that a massage therapist does not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. Because a massage therapist must be aware of existing physical conditions, I have stated all known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_