

# Massage Therapy Client Intake Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Date of Birth \_\_\_\_\_ Home Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Name Relationship Number

Are you presently taking any medication? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please Explain:

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Have you had a recent major surgical procedure or injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please Explain:

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Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Please Explain:

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Please circle your stress level:

Low 1 2 3 4 5 High

Are you allergic to any Lotions or Oils including Nut Oil? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please Explain: \_\_\_\_\_

Are you sensitive to smells or essential oils? \_\_\_\_\_ Yes \_\_\_\_\_ No

## Intake Form

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

### Musculo-Skeletal

Headaches  
Joint stiffness/swelling  
Spasms/cramps  
Broken/Fractured bones  
Strains/Sprains  
Back, hip pain  
Shoulder, neck, arm, hand pain  
Leg, foot pain  
Chest, ribs, abdominal pain  
Problems walking  
Jaw pain/TMJ  
Tendonitis  
Bursitis  
Arthritis (Rheumatoid/Osteo )  
Osteoporosis  
Scoliosis  
Other: \_\_\_\_\_

### Circulator/Respiratory

Dizziness  
Shortness of breath  
Fainting  
Cold feet or hands  
Cold sweats  
Stroke  
Heart condition  
Allergies  
Asthma  
High blood pressure  
Low blood pressure  
Other: \_\_\_\_\_

### Digestive

Indigestion  
Constipation  
Intestinal gas/bloating  
Diarrhea  
Irritable bowel syndrome  
Crohn's Disease  
Colitis  
Other: \_\_\_\_\_

### Nervous System

Numbness/tingling  
Fatigue  
Sleep disorders  
Ulcers  
Paralysis  
Herpes/shingles  
Cerebral Palsy  
Epilepsy  
Chronic Fatigue Syndrome  
Multiple Sclerosis  
Muscular Dystrophy  
Parkinson's Disease  
Other: \_\_\_\_\_

### Reproductive System

Pregnancy

### Skin

Rashes  
Allergies  
Athlete's foot  
Acne  
Impetigo  
Hemophilia

### Other

Loss of Appetite  
Depression  
Difficulty concentrating  
Hearing Impaired  
Visually Impaired  
Diabetes  
Fibromyalgia  
Post/Polio Syndrome  
Cancer  
Tuberculosis  
Other: \_\_\_\_\_

I understand that a massage Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the massage Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's signature \_\_\_\_\_ Date \_\_\_\_\_

## **Consent for Therapy and Waiver of Liability**

The undersigned (“Client”) hereby freely consents to receipt of massage services from:

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Licensed Massage Therapist’s Name

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information, and a written referral from Client’s primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manually therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.
2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client’s level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client’s part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.
3. Client hereby assumes fully responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist , to the fullest extent allowed by law.
4. Client, in signing this consent for Therapy and Waiver of Liability (“Consent”), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist

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Client Signature

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Client Printed Name

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Date

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Massage Therapist Signature

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Massage Therapist Printed Name

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Date