Live • Life • Well

Massage Therapy Client Intake Form

Name: ______________________________________ Birth Date: ________________

Have you ever received a professional massage? Y / N

If yes, frequency __________ Last Treatment Date: _______________

Do you have a history of the following?

- ☐ Headaches
- ☐ Neck pain
- ☐ Shoulder/arm pain
- ☐ Mid-back pain
- ☐ Low-back pain
- ☐ Abdominal pain
- ☐ Hip/leg pain
- ☐ Spasms/cramps
- ☐ Numbness/tingling
- ☐ Joint ache
- ☐ Sprains
- ☐ Seizures
- ☐ Disk problems
- ☐ Whiplash
- ☐ Broken bones
- ☐ Surgery
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Breathing difficulty
- ☐ Less range of motion
- ☐ Jaw pain/TMJ
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Nervous tension
- ☐ Allergies to oils
- ☐ Skin allergies
- ☐ Wear contacts
- ☐ Cancer
- ☐ Arthritis/bursitis
- ☐ Pregnancy

Do you have any of the following today?

- ☐ Headache
- ☐ Inflammation
- ☐ Severe pain
- ☐ Sunburn
- ☐ Irritated skin rash
- ☐ Poison ivy
- ☐ Open cuts
- ☐ Bruises
- ☐ Burns
- ☐ Cold/flu
- ☐ Nausea

Other conditions that would be helpful for me to know about?

____

Medications currently taking? For what reason?

____

Please check the areas that you do not give permission to receive massage:

- ☐ Back
- ☐ Legs
- ☐ Buttocks
- ☐ Arms
- ☐ Abdomen
- ☐ Chest
- ☐ Neck
- ☐ Head
- ☐ Face
- ☐ Feet

What results do you want from your massage session?

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Clients Signature

____

Date