Massage Client Intake Form

Personal Information

Name:		Date:	
Address:			
City:		State:	Zip:
Phone:		Email:	
DOB:		Age:	
Sex:		Height:	Weight:

History

Exercise Frequency: Exercise Type(s):

Do you smoke? Have you ever smoked? How Often?

How much water do you drink per day?

What medications are you currently using?

Previous complaints/surgeries/medications:

What is your major complaint?

Have you received massage therapy before?

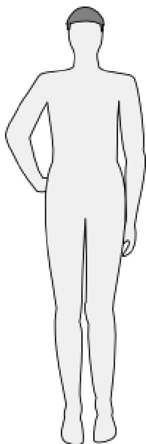
Goals for massage therapy today? ☐ Relaxation ☐ Rehabilitation ☐ High activity level maintenance

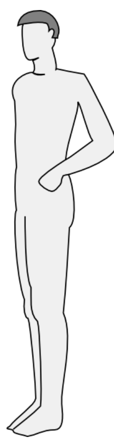
Preferred type of touch: ☐ Light/Meditative ☐ Heavy/Invigorating ☐ Deep/Trigger Point

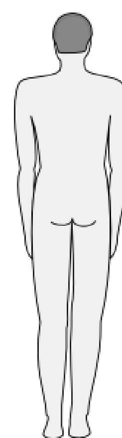
Do You Have Any of the Following Today? (Check All That Apply)

☐ Sunburn	☐ Cuts, Burns, Bruises	☐ Inflammation	☐ Irritated Skin Rash
☐ Headache	☐ Severe Pain	☐ Poison Ivy	☐ Cold or Flu
☐ Asthma	☐ Arteriosclerosis	☐ Pregnancy	☐ Arthritis
☐ Diabetes	☐ Varicose Veins	☐ Hernia	☐ Stomach Ulcers
☐ Epilepsy	☐ Dizziness	☐ Cancer	☐ Pins/Pacemaker
☐ Depression	☐ High Blood Pressure	☐ Contact Lenses	☐ Heart Disease
☐ Hemophilia	☐ Low Blood Pressure	☐ Musculoskeletal Problems	

Mark Areas of Discomfort







I understand that massage is designed for the purpose of relaxation and relief from tension, muscle spasms or poor circulation. The massage therapist cannot diagnose medical issues/diseases/disorders or perform spine palpitations.

Signature_______________________________________ Date_______________________________________