Massage Client Intake Form

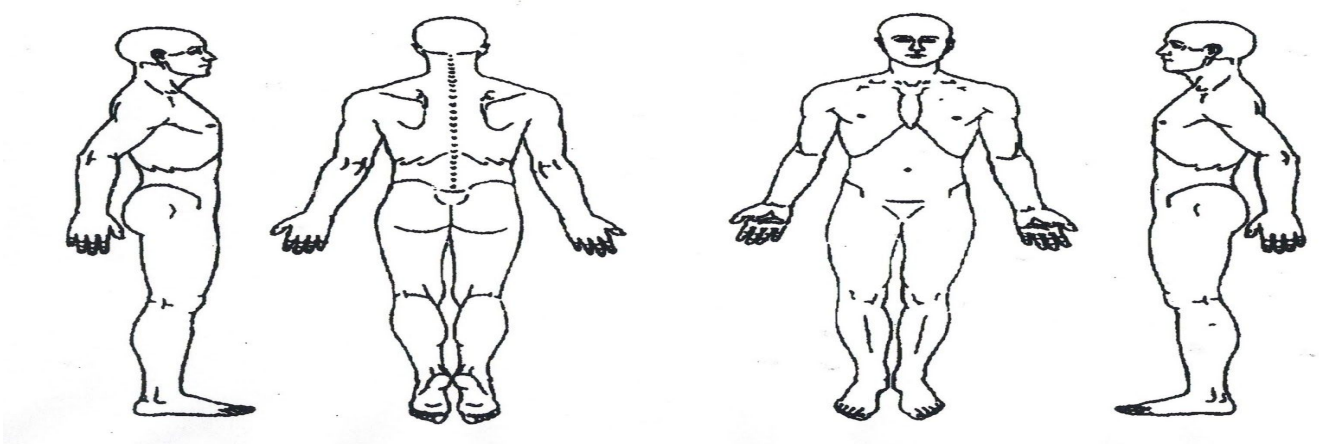
Who referred you? _____

Name: _____ Date of birth: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone number: _____ Age: _____
What is your major complaint? _____
Have you received massage therapy before? Yes No
What medications are you currently using? _____
Previous surgeries/ car accidents/ falls? _____
Women: Are you pregnant, trying or nursing? _____
Do you have any cuts/ bruises/ rashes/ STDs/Allergies? Yes No
If yes, please specify. _____

Do you have any of the following today?

Sunburn	_____	Headache	_____
Asthma	_____	Diabetes	_____
Depression	_____	Severe pain	_____
Varicose veins	_____	Dizziness	_____
High/ Low blood pressure	_____	Inflammation	_____

Please indicate on the picture below what is bothering you today.



I understand that massage is designed for the purpose of relaxation and relief from tension, muscle spasm or poor circulation. The massage therapist cannot diagnose medical issues/ disease/ disorders/ or perform spine palpation. Personal and medical information provided will not be disclosed unless given permission for such release.

Signature: _____ Date:_____