

Massage Client Intake Form

Date: _____

Patient Information

First name: _____ Last name: _____

Address: _____

Email: _____

Home phone: _____ Cell Phone: _____

Date of birth: _____ Gender: _____ Occupation: _____

Emergency Contact: _____

General and Medical Information

Y N Have you had a professional massage before? If yes, how often? _____

Y N Are you pregnant? If yes, how many weeks? _____

Y N Have you ever had surgery? When and what kind? _____

Y N Do you exercise regularly? If yes, what types? _____

What is your typical stress level? (1-10, 10 being high stress) _____

What are your stress triggers? _____

Are you currently on medication? Please list: _____

Are you currently seeing any of the following? (circle all that pertain): chiropractor/
medical doctor / naturopathic doctor / physiotherapist / acupuncturist / psychologist

Please check all that apply

- Skin condition/allergies/sensitivities _____
- Joint/bone condition-arthritis, osteoporosis, TMJD _____
- Headache/migraine, what triggers it? _____
- Recent injury/accident _____
- Circulatory condition _____
- Numbness/tingling _____
- Tendonitis, bursitis
- Diabetes
- Other medical history _____

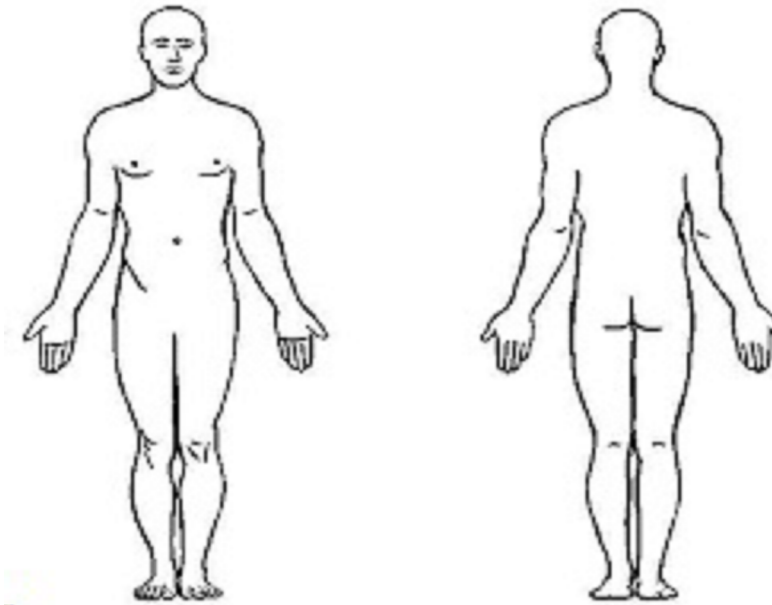
Massage information

What type of massage pressure do you prefer? (circle): deep /moderate/ light.

Is there an area you would prefer not to be massaged? _____

What is the specific area of concern?

Shade all areas of typical pain/discomfort/concern



How did the symptoms begin and when did they start? _____

What relieves the symptoms? _____

What aggravates the symptoms? _____

Massage Client Waiver Form

I acknowledge that the therapist is not a physician and does not diagnose illness or disease, or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my primary doctor for any ailments that I may be experiencing. I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical form, as provided by my therapist, and disclosed all of those medical conditions affecting me. It is my responsibility to keep my massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. By signing this form, I consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist.

Client's Name:(Please Print) _____

Signature of Client or Guardian: _____

Date: _____ Signature of Leanne Haughian _____