

Confidential Client Massage Intake Form

Name _____ Today's Date _____

Birth Date _____

Address _____

City/State/Zip Code _____

Home Phone ___-____-____ Work Phone ___-____-____

Cell Phone ___-____-____ Referred By _____

Occupation _____

Have you received Massage Therapy before? _____

If so, when was your last massage? _____

Is today's appointment for pain relief or relaxation? _____

If for pain relief, area of complaint _____

Cause of pain and date of onset _____

Please check any of the following which apply to you now.

- | | | |
|--|--|---|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Skin Infection | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach Disorders |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Contagious Cond./HIV |
| <input type="checkbox"/> Low/High Blood Pressure | | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Varicose Veins | | <input type="checkbox"/> Heart Conditions |
| <input type="checkbox"/> Circulatory Problems | | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Herniated Disk | | <input type="checkbox"/> Shortness of breath |

Please list and explain any other conditions that you have experienced _____

Please list any medications that you are currently taking _____

Have you had any operations or traumatic incidents? _____