Massage Intake Form

HIPAA Consent ▢

Personal Information **Date of Visit: _____**

Name: _____ Phone: _____

Email: _____ First Time Here:___ (Y/N)

Address: _____

Occupation: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____

The following Information will be used to help plan a safe and effective massage session. Please answer to the best of your ability.

1. Have you had a professional massage before: Yes/ No Frequency:_____
2. Do you have sensitive skin? (oils, lotions, etc) Yes/No
3. Do you sit for long hours at a workstation or commuting?
4. What repetitive motions do you perform daily at work, home or sports that have become uncomfortable or challenging:

   _____
5. Please explain how stress affects you:

   Mental distress _____

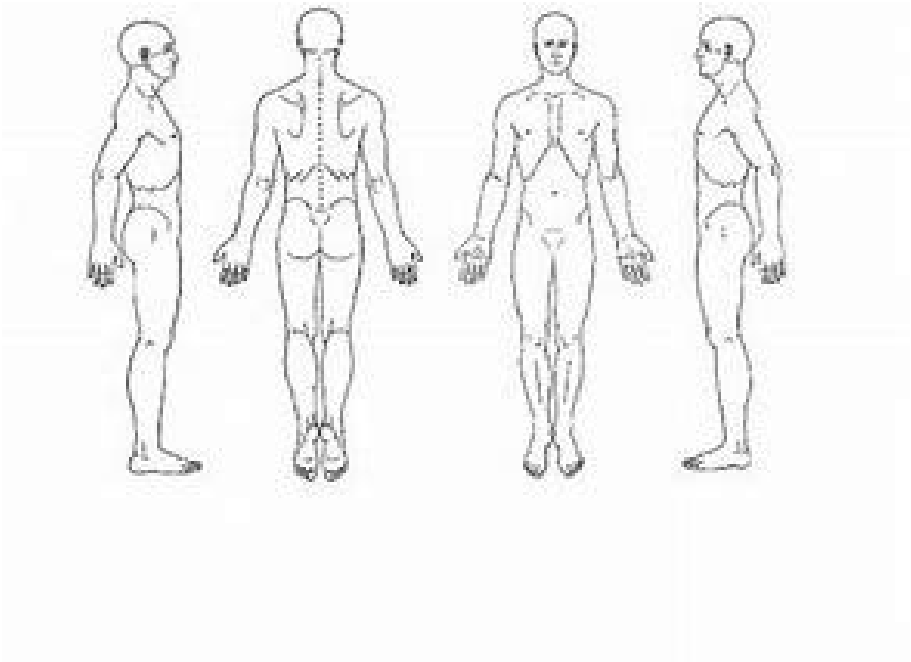
   Physical distress _____

   Emotional distress _____
6. Do you have any particular goals in mind for this session?

   _____
7. Do you have areas you DO NOT want massaged?

_____

On the diagram below, circle or mark the areas you are experiencing discomfort, pain stiffness.



Draping will be used during your massage session. Only the area being worked on will be undraped, then redraped before moving on to the next area. Your comfort and modesty are our highest priority.

Medical History

Please answer all questions accurately and to the best of your ability. Accurate information helps your Massage Therapist plan a safe session.

1. Are you currently under medical supervision with an ND, MD, Chiropractor or Acupuncturist? Yes/No
2. Are you currently taking any medications, herbs or vitamins/supplements:

_____

Please circle any conditions listed below. Some conditions are contraindicated for massage.

Contagious skin condition	Open Sores/Wounds	Fibromyalgia
Easy Bruising	Recent accident or Injury	Tendonitis
Fracture	Sprain/Strain	Joint Disorder/
Artificial Joint(s)	Carpal Tunnel Syndrome	Blood Clots
Fever (within last 24 hours)	Cold/Flu (past 24 hours)	Cancer
Allergies/Sensitivities	Heart Condition	Scoliosis
High or Low Blood Pressure	High Cholesterol	Varicose Veins, Deep
Vein Thrombosis	TMJ	Epilepsy/ Seizures
Arthritis (Rheumatoid or Osteo)	Headaches/ Migraines	Diabetes
Decreased sensation/ Neuropathy	Autoimmune Disorders	Pregnant/Weeks:

Surgeries (explain):_____

3. Is there anything else about your health history that you would like your massage therapist to know to give you a safe and effective massage session today?

_____

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of soft tissue tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure or strokes can be adjusted.

Massage should not be substituted for medical care. Massage Therapists cannot and will not diagnose a medical condition.

Massage is not:

- A substitute for medical care
- Spinal manipulations
- A diagnosis of any medical condition

I agree that I have answered all the questions to the best of my ability, honestly and agree to keep the therapist current on any changes in my medical profile. I do not hold my Massage Therapist or Clinic liable for medical conditions that may arise from not keeping my medical profile current.

Signature of Client/ Guardian **Date:**

_____

Signature of Student Massage Therapist **Date:**

_____

Signature of Supervising Student Clinic Massage Therapist **Date:**

_____

Clients under the age of 18 are considered minors and must have an adult or guardian sign a Minor Authorization form **before** being treated. *Initial of Guardian:*_____