Power of Touch Massage & Bodywork - Client Intake Form

Personal Information

Name ______________________________ Email ______________________________

Phone (**Cell/Provider**) ______________________________ Phone (Home) ______________________________

Address ______________________________

City ______________________________ State __________ Zip ______________

Date of Birth ______________________________ Occupation ______________________________

Emergency Contact ______________________________ Phone ______________________________

The following information will be used to help plan safe and effective massage sessions.
Date of Initial Visit ______________________________

1. Have you had a professional massage before? Yes ☐ No ☐
   If yes, how often do you receive massage therapy? ______________________________
2. Do you have any difficulty lying on your front, back, or side? Yes ☐ No ☐
   If yes, please explain ______________________________
3. Do you have any allergies to oils, lotions, or ointments? Yes ☐ No ☐
   If yes, please explain ______________________________
4. Are you wearing...? contact lenses ☐ dentures ☐ a hearing aid ☐
5. Do you follow a regular exercise program? ____________ What kind? ____________
6. Do you sit for long hours at a workstation, computer, or driving? Yes ☐ No ☐
   If yes, please describe ______________________________
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes ☐ No ☐
   If yes, please describe ______________________________
8. Do you experience stress in your work, family, or other aspect of your life? Yes ☐ No ☐
   If yes, how do you think it has affected your health?
   Muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other ______________________________
9. Goals in mind for this massage session? ☐ Relaxation ☐ Rehabilitation ☐ High activity level maintenance
10. Preferred type of touch: ☐ Light/Meditative ☐ Heavy/Invigorating ☐ Deep/Trigger Point

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11. Major/Minor Complaints

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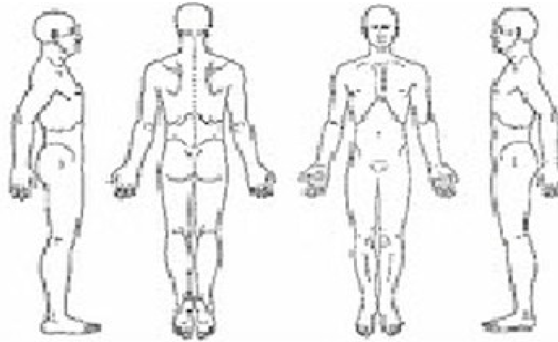

Circle any specific areas you would like the massage therapist to concentrate on during the session

Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

12. Are you currently under medical supervision? Yes ☐ No ☐
    If yes, please explain
    ____
13. Do you see a chiropractor? Yes ☐ No ☐ If yes, how often?
    ____
14. Are you currently taking any medication? Yes ☐ No ☐
    If yes, please list
    ____
15. Have you ever had any serious injuries/illness, broken bones, or surgeries? Yes ☐ No ☐
    If yes, please list
    ____
16. Please check any condition listed below that applies to you:
    - ☐ contagious skin condition
    - ☐ phlebitis
    - ☐ open sores or wounds
    - ☐ varicose veins/deep vein thrombosis/blood clots
    - ☐ easy bruising
    - ☐ joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
    - ☐ recent accident or injury
    - ☐ osteoporosis
    - ☐ atherosclerosis
    - ☐ epilepsy
    - ☐ artificial joint
    - ☐ headaches/migraines
    - ☐ sprains/strains
    - ☐ cancer
    - ☐ current fever or swelling
    - ☐ diabetes
    - ☐ swollen glands
    - ☐ decreased sensation
    - ☐ circulatory disorder
    - ☐ back problems/buldging or ruptured discs
    - ☐ heart condition
    - ☐ Fibromyalgia
    - ☐ high or low blood pressure
    - ☐ TMJ
    - ☐ head or neck injury/problems
    - ☐ carpal tunnel syndrome/tennis elbow
    - ☐ pregnancy, how many months?
    - ☐ digestive problems/ulcers
    - ☐ chest pain/shortness of breath
    - ☐ dizzy or fainting spells

    Please explain any condition that you have marked above

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17. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?
____

Informed written consent must be provided by parent or legal guardian for any client under the age 17.

I, ______________________________(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client ____ Date _____________________

Signature of Massage Therapist ____ Date _____________________

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