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# Massage therapy client intake form template



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## CONFIDENTIAL MASSAGE CLIENT INTAKE FORM

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Email \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_  
Who referred you? \_\_\_\_\_  
Have you received massage in the Past? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type(s) of massage? \_\_\_\_\_

Please describe any Accidents, Injuries or Surgeries:  
More than 5 years ago \_\_\_\_\_  
Less than 5 years ago \_\_\_\_\_  
Are you receiving medical or chiropractic care currently? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe and by what doctor(s) \_\_\_\_\_  
Are you taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

	Heavy	Moderate	Light/None
Do you have neck pain?			
Do you have shoulder pain?			
Do you have wrist/hand pain?			
Do you have back pain?			
Do you have leg pain?			

## Therapeutic Massage - Client Intake Form

**Personal Information**  
Name \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Email (optional) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_  
Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

**Message Information**  
How did you hear about us? \_\_\_\_\_  
Have you ever had a professional massage before?  No  Yes  
If yes, how often do you receive massage therapy? \_\_\_\_\_  
If yes, do you have any preferences?  No  Yes  
Specify:  Light pressure  Medium pressure  Deep pressure  
 Trigger point therapy  Energy work  
 Other \_\_\_\_\_

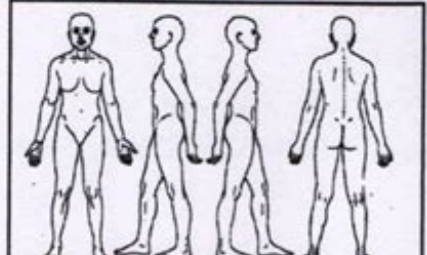
What type of massage are you seeking today?  
 Relaxation  Deep Tissue/Therapeutic  Pregnancy  
 Senior  Integrated Bodywork (Incentive)  
 Other \_\_\_\_\_

Are you sensitive to fragrances or perfumes?  Yes  No  
Do you have sensitive skin?  Yes  No  
Do you wear contact lenses?  Yes  No  
Do you exercise regularly?  Yes  No  
If so, what type(s)? \_\_\_\_\_

What are your common areas of pain or tension?  
\_\_\_\_\_

**Medical History**  
Do you suffer from chronic or persistent pain/discomfort?  
If so, how long? \_\_\_\_\_  
Do you know what caused it or when the symptoms seem to get worse or better? \_\_\_\_\_  
Do you see a chiropractor?  Yes  No  
If so, how often? \_\_\_\_\_  
Are you currently under medical care?  Yes  No  
Are you currently taking any prescription medication? If so, for what? \_\_\_\_\_

Please indicate any conditions that you have had or currently have:  
 Headaches, migraines  Varicose veins  
 Allergies, sensitivity  Pregnancy  
 Arthritis, tendonitis  Blood clots  
 Cancer, tumors  Stroke / Neck injuries  
 TMJ problems  Diabetes  
 Abnormal skin conditions  Psoriasis  
 Heart/circulation problems  Stroke/Alzheimer's  
 Joint replacement / Surgery  Osteoporosis  
 High / Low blood pressure  Spains, strains  
 Major accident  Recent injuries  
 Lack of or reduced feeling / sensation



I hereby declare and certify that I take part of the massage therapy my own responsibility. I declare that I am an adult without a doctor's or health insurance professional's advice, which would be dangerous for me to have a massage. I informed the therapist about all my health problems. I understand that the Charles Rowland Massage Centre is not responsible for the potential problems with me during or after the treatment. With my present statement I voluntarily sign away liability any damage against Charles Rowland Massage Centre.

## Client Intake Form

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ DOB: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail \_\_\_\_\_  
Referred by: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
In case of emergency: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Occupation  Male  Female Physician \_\_\_\_\_  
Health Insurance Carrier \_\_\_\_\_

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage or bodywork session?  Yes  No If yes, how recently? \_\_\_\_\_  
What are your massage or bodywork goals? \_\_\_\_\_  
What kind of pressure do you prefer?  Light  Medium  Firm

If you answer "Yes" to any of the following questions, please explain as clearly as possible.

<input type="checkbox"/> Yes <input type="checkbox"/> No Do you frequently suffer from stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have asthma?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have osteoporosis?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience frequent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have back pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have neck pain?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any chronic conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any recent injuries?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any recent injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any recent surgery?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any chronic conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any chronic conditions?
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any chronic conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any chronic conditions?
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<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any chronic conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any chronic conditions?

I understand that the massage bodywork is given for the benefit of the client and not for the benefit of the therapist. I understand that I am an adult without a doctor's or health insurance professional's advice, which would be dangerous for me to have a massage. I informed the therapist about all my health problems. I understand that the Charles Rowland Massage Centre is not responsible for the potential problems with me during or after the treatment. With my present statement I voluntarily sign away liability any damage against Charles Rowland Massage Centre.

## SOAP Notes

Client Name \_\_\_\_\_ Date \_\_\_\_\_

### Preferences

Massage Media \_\_\_\_\_ Table Setup \_\_\_\_\_

Hot or Cold Therapies \_\_\_\_\_ Music \_\_\_\_\_

Other \_\_\_\_\_

### SUBJECTIVE

Client Goals \_\_\_\_\_

Symptoms \_\_\_\_\_

\_\_\_\_\_

Improve with \_\_\_\_\_ Worsen with \_\_\_\_\_

### OBJECTIVE

Visual \_\_\_\_\_

\_\_\_\_\_

Palpation \_\_\_\_\_

\_\_\_\_\_

Modalities Applied \_\_\_\_\_

\_\_\_\_\_

### ASSESSMENT

Changes Achieved \_\_\_\_\_

\_\_\_\_\_

Goals \_\_\_\_\_

### PLAN

Treatment Plan \_\_\_\_\_

Self-Care Plan \_\_\_\_\_

Legend

★ Inflammation

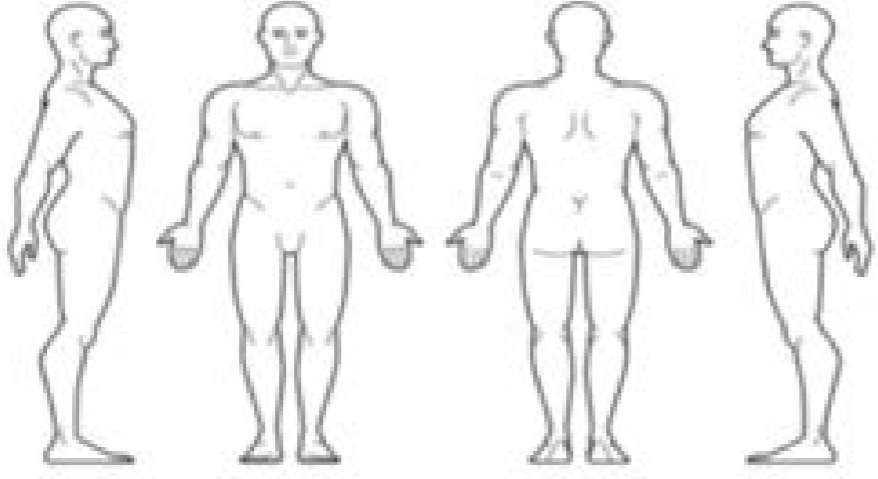
↺ or ↻ Rotation

→ Long

● Tender Point

✱ Trigger Point

↑ Elevation



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Of course, you can add, modify, edit, or remove all the desired fields - our drag and drop editor is here to help with all this! As our Formula Editor has a real-time premise, you can immediately see any changes. Make the form skill and enter it into a web page or post the form URL anywhere you want. Only ... PlanShare paid This dontolytic procedure The doctor's historic form with its patients to improve their med ... paid paid in this way by disclosing certain dentures with patient consent. Customize the Labor ... Make sure your massage therapy customers are well informed before taking on benefit ... freelearn a little about each patient and ensure it is safe for them to receive therapeutic massage ... paid Placercing this massage consent form template in any way you want and publish ... Planyou can modify anything you want in this claim form for lead maternity caregiver. No needable coding ... 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