

Intuitive Hands Massage: Client Intake Form



Date of Initial Visit: _____

Personal Information

Name: _____

Address: _____

City, State, Zip: _____

Phone(s): _____

Email: _____

Occupation: _____

Marital Status: _____

Referred by: _____

Emergency Contact: _____

Emergency Contact Phone: _____

Physician's Name: _____

Physician's Phone: _____

Massage Experience

Have you had a professional massage before? Y N

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?

How long have you been receiving massage therapy? _____

Frequency of massages? _____

What are your goals for treatment? _____

Health History

Musculoskeletal

- Bone or joint disease
- Tendonitis/Bursitis
- Arthritis/Gout
- Jaw pain (TMJ)
- Lupus
- Spinal Problems
- Migraines/Headaches
- Osteoporosis

Circulatory

- Heart Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymphedema
- Thrombosis/Embolism

Respiratory

- Breathing Difficulty/Asthma
- Emphysema
- Allergies, specify: _____
- Sinus Problems

Nervous System

- Shingles
- Numbness/Tingling
- Pinched Nerve
- Chronic Pain
- Paralysis
- Multiple Sclerosis
- Parkinson's Disease

Reproductive

- Pregnant, weeks _____
- Ovarian/Menstrual Problems
- Prostate

Current Health

Do you exercise regularly and/or participate in any sports? Y N
If yes, what kind of exercise/sports? _____

Do you perform any repetitive movement in your work, sports or hobby? Y N
If yes, describe _____

Do you sit for long hours at a workstation, computer or driving? Y N
If yes, describe _____

Do you experience stress in your work, family, or other aspect of your life? Y N
If yes, describe _____

Are you experiencing tension, stiffness, discomfort or pain? Y N
If yes, describe _____

Have you recently had an injury, surgery, or areas of inflammation? Y N
If yes, describe _____

Do you have sensitive skin? Y N

Do you have allergies to oils, lotions or ointments? Y N
If yes, please explain _____

List any medications you are currently taking _____

List any known allergies: _____

Skin

- Allergies, specify: _____
- Rashes
- Cosmetic Surgery
- Athlete's Foot
- Herpes/Cold Sores

Digestive

- Irritable Bowel Syndrome
- Bladder/Kidney Ailment
- Colitis
- Crohn's Disease
- Ulcers

Psychological

- Anxiety/Stress Syndrome
- Depression

Other

- Cancer/Tumors
- Diabetes
- Drug/Alcohol/Tobacco Use
- Contact Lenses
- Dentures
- Hearing Aids

Any other medical condition(s) not listed: _____

Please explain any of the conditions that you marked above: _____

Adapted from AMTA 8/20/11