Client Intake Form - Therapeutic Massage

Bodywork Therapy WELLNESS

Client Information

Name _____ Email _____

Phone (cell/day) _____ DOB_____ Age _____

Address _____City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Occupation _____ Referred by _____

Health Information

Are you taking any medications? ☐ yes ☐ no If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no If yes, please list: _____

Are you pregnant? ☐ yes ☐ no If yes, how many months: _____ Due date: _____

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☐ no

If yes, please describe: _____

(Check all that apply)

- ☐ Areas of swelling
- ☐ Autoimmune disorder
- ☐ Back / neck problems
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ Bruise easily
- ☐ Bursitis
- ☐ Cancer
- ☐ Contagious condition
- ☐ Decreased sensation
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart condition
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Multiple sclerosis
- ☐ Neurological condition
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Sciatica
- ☐ Seizures
- ☐ Stroke
- ☐ Tendinitis
- ☐ TMJ disorder
- ☐ Varicose veins
- ☐ Vertigo / dizziness

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? _____

History of joint replacement surgery? ☐ yes ☐ no Which joint(s)? _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no

Please describe: _____

Please describe any other injuries or health conditions: _____

Massage Information

Have you had professional massage before? ☐ yes ☐ no How recently? _____

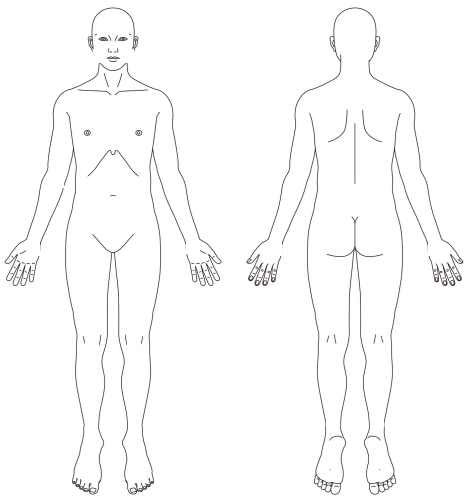
Reason for seeking massage:

☐ Integrative Massage ☐ TMJ Massage

Specifics: _____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of discomfort
(if completing digitally, hover over images and click when the mouse turns to a hand)



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

*Client Signature _____ Date _____

Therapist Signature _____ Date _____

*By typing your name, you are signing this form electronically

Please bring this form with you to your first appointment, or email it to
bethhabig@bodyworktherapywellness.com