Massage Client Intake Form

Name: ____
Date: ______________
Address: ___________________________ **City:** _______________
Zip: ________
E-mail: ____
Date of birth: ____
Phone Number: ____
Occupation: ____
How did you hear about us? _______________________________________

GENERAL& MEDICAL INFORMATION

Have you ever received a professional massage? YES NO
How recently? ___________

What type of massage do you prefer? LIGHT MEDIUM FIRM OTHER____________
Are you sensitive to scents: YES NO?
Do you have any allergies to oils, lotions, or ointments? YES NO
Check areas of your body that you do NOT want to receive massage:
___ Face ___ Feet ___ Glutes ___ Scalp ___Other

Please mark the following conditions that apply to you:
____**PREGNANT** _______How many weeks?
____contagious skin condition
____high or low blood pressure
____circulatory disorder
____respiratory issues
____blood clots
____open sores or wounds
____frequent headaches
____joint disorder or artificial joint
____recent accident or injury
____cancer
____numbness/tingling
____decreased/increased sensation
____allergies – perfumes, skin irritants
____current fever or swollen glands
____heart condition
____warts
____scoliosis
____diabetes
____edema
____ athletes foot
____asthma
____stress
____gout
____varicose veins
____osteoporosis
____epilepsy
____headaches

If you answered "YES" to any of the above, please explain below:
____
____
____
Please list any other medical concerns/issues/diagnoses of which we should be aware:
____
____
____

(Please Turn Page Over) >

LMT NOTES

Client Name: ___________________________

[Type here]