Client Intake Form – Allgood Therapeutic Massage

Name_____ Phone (Home)_____Phone (Mobile)_____

Address_____

City/State/Zip_____

Email_____ Date of Birth_____ Occupation_____

Emergency Contact_____ Phone_____

Preferred primary contact method ( ) Phone ( ) E-mail ( ) Text

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_____

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

4. Are you currently taking any medication? Yes No

If yes, please list_____

5. Please check any condition listed below that applies to you:

( ) diabetes	( ) high/low blood pressure	( ) contagious skin condition
( ) back/neck problems	( ) deep vein thrombosis/blood clots	( ) open sores or wounds
( ) varicose veins	( ) joint disorder/rheumatoid arthritis	( ) easy bruising
( ) osteoporosis	( ) osteoarthritis/tendonitis	( ) recent accident or injury
( ) epilepsy	( ) cancer	( ) recent fracture
( ) headaches/migraines	( ) Fibromyalgia	( ) recent surgery
( ) heart condition	( ) TMJ	( ) sprains/strains
( ) pregnancy If yes, how many months?_____	( ) carpal tunnel syndrome	( ) current fever
		( ) swollen glands

Please explain any condition that you have marked above_____

_____

6. 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? _____

_____

Draping will be used during the session – only the area being worked on will be uncovered.
Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I 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 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 a 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.

Signature of client _____Date_____

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