



Master Therapy Massage Center

CONFIDENTIAL CLIENT INFORMATION MASSAGE INTAKE FORM

Welcome! We want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your therapy session, please, let us know.

NAME _____ CELL # _____ HOME # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ AGE _____ MALE FEMALE MARITAL STATUS _____

OCCUPATION _____ WORK # _____ REFERRED BY _____

HAVE YOU EVER RECEIVED MASSAGE THERAPY? YES NO

TYPE OF MASSAGE EXPERIENCED: DEEP TISSUE SWEDISH OTHER _____

ARE YOU TAKING MEDICATIONS? _____ DESCRIBE _____

ARE YOU PREGNANT? YES NO HAVE YOU CONSUMED ALCOHOL IN THE PAST 24 HOURS? YES NO

DO YOU HAVE A HISTORY OF THE FOLLOWING?

- | | | |
|-------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> accident | <input type="checkbox"/> sprains | <input type="checkbox"/> mastectomy |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> seizures | <input type="checkbox"/> breast augmentation |
| <input type="checkbox"/> whiplash | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> headaches | <input type="checkbox"/> nervous tension | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> arthritis, bursitis or
gout | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> upper back pain | <input type="checkbox"/> allergies to oils or
perfumes | <input type="checkbox"/> stroke |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> wear contacts | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> lower back pain | <input type="checkbox"/> scoliosis | <input type="checkbox"/> cancer |
| <input type="checkbox"/> joint ache | <input type="checkbox"/> surgery | <input type="checkbox"/> colitis |
| <input type="checkbox"/> decreased range
of motion | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> HIV |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> carpal tunnel syndrome | <input type="checkbox"/> _____ |
| <input type="checkbox"/> sciatica | | <input type="checkbox"/> _____ |

Please, indicate your consumption level:

	None	Light	Moderate	Heavy
salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

- | | |
|---------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> sunburn | <input type="checkbox"/> open cuts, bruises, burns |
| <input type="checkbox"/> inflammation | <input type="checkbox"/> irritated skin rash |
| <input type="checkbox"/> severe pain | <input type="checkbox"/> poison ivy |
| <input type="checkbox"/> headache | <input type="checkbox"/> cold/flu |

WHAT ARE YOUR GOALS/EXPECTATIONS FOR THIS THERAPY SESSION?

PLEASE READ THE FOLLOWING AND SIGN BELOW:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

DATE _____ SIGNATURE _____

PLEASE, INDICATE THE AREAS
OF DISCOMFORT WITH AN "X"

