Client Intake

the MASSAGE CENTER est 1989

Name	Height	Weight
Address	Occupation(s)	
City State Zip	Referred By	
Birthday / /	Is this your first massage?	
Email	Emergency Contact	
Cell Phone	His/Her phone	

What are your current physical activities and exercise routines?

What are your current relaxation and wellness habits?

Recent surgeries, injuries, or inflammation?

Overall stress level on a scale of 1-10? Current stress level on a scale of 1-10?

What are your treatment goals for today?

What are your current medications?

Please check all that currently apply

Head & Neck
- ______ Headaches
- ______ Neck pain/tightness
- ______ Migraines

Other ______________

Respiratory
- ______ Asthma/Bronchitis
- ______ Smoker
- ______ Allergies

Specify ______________

Other ______________

Cardiovascular
- ______ High Blood Pressure
- ______ Low Blood Pressure
- ______ Blood Clots

Other ______________

Musculoskeletal
- ______ Aching Muscles

Where ______________
- ______ Broken Bones

Where ______________
- ______ Sprains/Strains

Where ______________
- ______ Inflamed Joints
- ______ TMJ Syndrome
- ______ Back Pain
- ______ Fibromyalgia
- ______ Scoliosis
- ______ Carpal Tunnel
- ______ Sciatica

Other ______________

Blood
- ______ HIV/AIDS
- ______ Anemia
- ______ Sickle Cell Anemia

Other ______________

Nervous System
- ______ Insomnia
- ______ Anxiety
- ______ Pinched Nerve
- ______ Paralysis
- ______ Shingles

Other ______________

Skin
- ______ Allergies

Specify ______________

Where ______________
- ______ Rashes

Where ______________
- ______ Open Sores/Cuts
- ______ Bruise Easily
- ______ Athlete's Foot

Other Varicose Veins ______________

Reproductive
- ______ Currently Pregnant

Weeks ______________
- ______ Trying to get Pregnant
- ______ Menstrual Cramps

Other Menopause ______________

Other
- ______ Cancer

Desc. ______________

Date ______________
- ______ Breast Implants

Date ______________
- ______ Multiple Sclerosis
- ______ Parkinson's
- ______ Tuberculosis
- ______ Epilepsy
- ______ Diabetes
- ______ Digestive Disorders

Other ______________

I understand massage/bodywork is not a substitute for medical care and any information that is provided to me by the massage therapist is not diagnostic but for educational purposes only.
I will, as much as possible, participate in my own healing.
I have stated all my known medical conditions and take it upon myself to keep The Massage Center updated on my physical health.

Signature______________________________________ Date_____________________