# Client Intake Form

**Date of initial visit_____**

## Contact Information

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____ Email ok? Yes ☐ No ☐

Referred by: _____

Emergency contact: _____ Phone: _____

Physician/Health-care Provider name: _____ Phone: _____

Is this massage medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Have you had COVID? Yes __ No __When? _____ Do you have COVID related blood clots? Yes __ No __
Other 'long haul' symptoms? Yes __ No __ If Yes, explain:_____

## Massage Experience

Have you ever received professional massage/bodywork before? Yes ☐ No ☐ How recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

Reason for initial visit: _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes ☐ No ☐

If yes, please explain_____

_____

Current medications:_____

_____

Have you had any injuries or surgeries in the past that may influence today's session?

_____

## Health History

**Musculoskeletal**

___ Bone or joint disease
___ Tendonitis/Bursitis
___ Arthritis/Gout
___ Jaw pain (TMJ)
___ Lupus
___ Spinal problems/Scoliosis
___ Migraines/Headaches
___ Osteoporosis

**Circulatory**

___ Heart condition
___ Phlebitis/Varicose Veins
___ Blood Clots
___ High/Low Blood Pressure
___ Lymphedema
___ Thrombosis/Embolism

**Respiratory**

___ Breathing difficulty/Asthma
___ Emphysema
___ Allergies, specify:
_____
___ Sinus Problems

**Nervous System**

___ Shingles
___ Numbness/Tingling
___ Pinched Nerve
___ Chronic Pain
___ Paralysis
___ Multiple Sclerosis
___ Parkinson's Disease

**Reproductive**

___ Pregnant, stage _____
___ Ovarian/Menstrual
___ Prostate

**Skin**

___ Allergies, specify
_____
___ Rashes
___ Cosmetic Surgery
___ Athletes Foot
___ Herpes/Cold Sores

**Digestive**

___ Irritable Bowel Syndrome
___ Bladder/Kidney.
___ Colitis
___ Crohn's Disease
___ Ulcers

**Psychological**

___ Anxiety
___ Stress
___ Depression

**Other**

___ Cancer/Tumors
___ Diabetes
___ ContactLenses
___ Dentures
___ Hearing Aids

**Other medical conditions**

_____
_____
_____

# Consent for Treatment

I understand that there are medical conditions that are contraindicated to massage therapy. I affirm that I have listed all my known medical conditions and answered all questions honestly on this intake form. I agree to keep Centered Healing Therapeutic Massage updated with any changes to my medical profile

I understand that massage therapists must work within their scope of practice and that they do not diagnose medical conditions or prescribe medical treatment. I will address conditions that are beyond the scope of massage therapy with a medical professional

If I experience any discomfort during a session, I will immediately inform my massage therapist so that adjustments can be made to increase my comfort and the effectiveness of the session.
Understanding all the above, I give my consent to receive massage therapy at Centered Healing Therapeutic Massage

Client Signature: _____ Date: _____

Parent or Guardian Signature (if a minor): _____ Date: _____

abmp
MEMBER
Associated Bodywork & Massage Professionals