Client Intake Form – Therapeutic Massage

Personal Information:

Name____________________ Pronouns__________ Date of Initial Visit__________

Phone (primary)________________ Phone (secondary) ________________

Address/ City/State/Zip____________________

Email____________________ Date of Birth__________

Emergency Contact & Phone____________________

Yes, add me to the monthly Armonía Health electronic newsletter! ☐

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

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 ____________________

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses ( ) dentures ( ) a hearing aid ( ) ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No

   If yes, please describe ____________________

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No

   If yes, please describe ____________________

8. Do you experience stress in your work, family, or other aspect of your life? Yes No

   If yes, how do you think it has affected your health?

   muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other ____________________

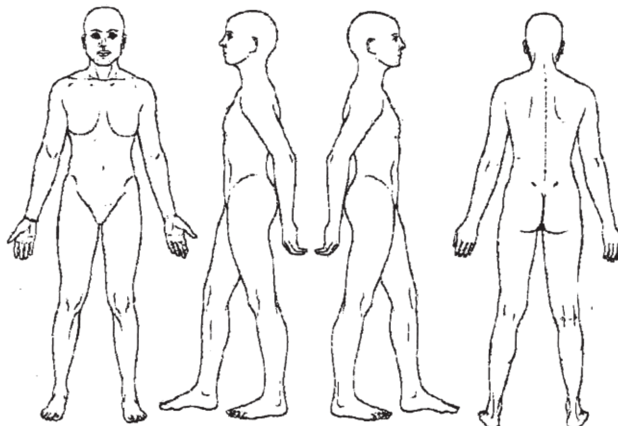
9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

   If yes, please identify ____________________

10. Do you have any particular goals in mind for this massage session? Yes No

    If yes, please explain ____________________

Circle any specific areas where you have chronic pain or discomfort:



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Medical History

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

11. Are you currently under medical supervision? Yes No

If yes, please explain ______________________________

12. Do you see a chiropractor? Yes No If yes, how often? ______________________________

13. Are you currently taking any medication? Yes No

If yes, please list ______________________________

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

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

Please explain any condition that you have marked above ______________________________

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15. 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? ______________________________

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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,______________________________(print name) 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 during 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 ______________

Signature of Massage Therapist______________________________Date ______________