# Moasis Therapeutic Massage
# Client Intake Form

## Personal Information:

Name _____ Date of First Visit _____

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____

City/State/Zip _____

Email _____ Date of Birth _____ Occupation _____

Emergency Contact _____ Phone _____

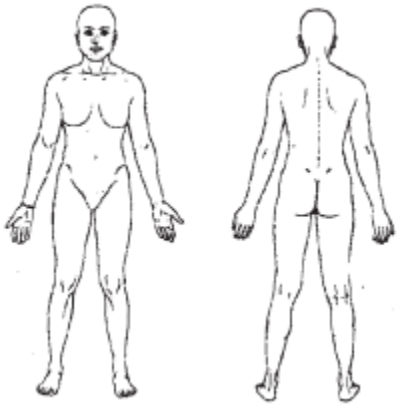
**How did you hear about us?**

□ Referral from: _____ □ Website □ Gift Certificate
□ Location □ Advertisement: _____

**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. Are you wearing contact lenses ( ) a hearing aid ( ) ?
5. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please describe _____
6. Is there a particular area of the body where you are experiencing tension, stiffness, pain
   or other discomfort? Yes No
   If yes, please identify _____
7. Do you have any particular goals in mind for this massage session? Yes No
   If yes, please explain _____

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



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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.**

8. Are you currently under medical supervision? Yes No

If yes, please explain _____

9. Do you see a chiropractor? Yes No If yes, how often?_____

10. Are you currently taking any medication? Yes No

If yes, please list _____

11. Any recent surgeries? Yes No

If yes, please explain _____

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

| | |
|---|---|
| ( ) contagious skin condition | ( ) edema/swelling |
| ( ) open sores or wounds | ( ) deep vein thrombosis/blood clots |
| ( ) easy bruising | ( ) joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| ( ) recent accident or injury | ( ) osteoporosis |
| ( ) recent fracture | ( ) epilepsy/seizures |
| ( ) recent surgery | ( ) headaches/migraines |
| ( ) artificial joint/pins | ( ) cancer |
| ( ) sprains/strains | ( ) diabetes |
| ( ) current fever | ( ) numbness/tingling |
| ( ) sciatica | ( ) back/neck problems |
| ( ) allergies/sensitivity | ( ) Fibromyalgia |
| ( ) heart condition | ( ) TMJ/jaw pain |
| ( ) high or low blood pressure | ( ) carpal tunnel syndrome |
| ( ) circulatory disorder | ( ) multiple sclerosis |
| ( ) varicose veins | ( ) pregnancy - If yes, how many weeks? |

Please explain any condition that you have marked above _____

_____

_____

13. 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? _____

_____

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 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 also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. 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 _____