Massage Intake Form

Client health history, treatment consent and session record for a massage therapy practice.

ORGANISATION

DATE

Client details

FULL NAME

DATE OF BIRTH

DATE OF VISIT

MOBILE

EMAIL

OCCUPATION

EMERGENCY CONTACT AND PHONE

GP NAME AND PRACTICE

HOW DID YOU HEAR ABOUT THIS PRACTICE

REFERRED BY

Reason for visit

WHAT BRINGS YOU IN TODAY

WHERE IS THE PAIN OR TENSION

HOW LONG HAS IT BEEN THERE

BETTER OR WORSE RECENTLY

WHAT MAKES IT WORSE

WHAT GIVES RELIEF

PRESSURE PREFERENCE

- [ ] Light
- [ ] Medium
- [ ] Firm
- [ ] Deep

AREAS TO AVOID ENTIRELY

- [ ] Face and scalp
- [ ] Abdomen
- [ ] Feet
- [ ] Glutes
- [ ] Chest
- [ ] Neck
- [ ] None
- [ ] Other, see notes

Health history

Some conditions change how or whether massage should be given. Please complete all of this.

TICK ANYTHING THAT APPLIES TO YOU

- [ ] Pregnant
- [ ] High or low blood pressure
- [ ] Heart condition
- [ ] Blood clot or DVT history
- [ ] Diabetes
- [ ] Osteoporosis
- [ ] Recent surgery
- [ ] Recent injury or fracture
- [ ] Cancer, current or past
- [ ] Skin condition or open wound
- [ ] Varicose veins
- [ ] Epilepsy
- [ ] Arthritis
- [ ] Fibromyalgia
- [ ] Migraines
- [ ] Nerve pain or numbness

DETAILS FOR ANYTHING TICKED ABOVE

CURRENT MEDICATIONS

ALLERGIES (OILS, NUTS, LATEX, FRAGRANCE)

PREVIOUS MASSAGE THERAPY AND HOW YOU FOUND IT

Therapist notes

Completed by the therapist. Mark areas of concern on your own body chart and attach.

OBSERVATIONS AND FINDINGS

TECHNIQUES USED

AREAS TREATED

CLIENT RESPONSE AND AFTERCARE GIVEN

RECOMMENDED FOLLOW-UP

Consent

- [ ] The information I have given is accurate and complete to the best of my knowledge
- [ ] I understand massage therapy is not a substitute for medical diagnosis or treatment
- [ ] I will tell my therapist during the session if pressure is uncomfortable or anything causes pain
- [ ] I understand draping is used at all times and I may stop the session at any point
- [ ] I agree to update my therapist on any change to my health before future sessions
- [ ] I have read and understood the cancellation policy

CLIENT SIGNATURE | PRINT NAME | DATE

THERAPIST SIGNATURE | PRINT NAME | DATE