MASSAGE THERAPY INTAKE FORM

Business Name: _____

Date: _____

Clinical intake form for licensed massage therapists. Includes detailed health history, pain assessment body map, and treatment consent.

** Required fields*

Full Name *

_____

Email *

_____

Phone Number *

_____

Date of Birth *

_____

Address *

_____

Emergency Contact *

_____

Emergency Contact Phone *

_____

Primary care physician

_____

Physician phone

_____

Primary complaint *

Describe your main issue

When did this start?

_____

What makes it better?

What makes it worse?

Treatment goals *

Options: Pain reduction / Increased mobility / Stress relief / Injury recovery / Athletic performance / Prenatal comfort / General relaxation

Past surgeries or injuries

Current medications and supplements

Health conditions (check all that apply)

Arthritis, fibromyalgia, sciatica, herniated disc, carpal tunnel, TMJ, migraines...

Cardiovascular conditions

High blood pressure, heart disease, blood clots, varicose veins...

Are you pregnant? *

Options: Yes / No / N/A

Pressure preference *

Options: Light / Medium / Firm / Deep

☐ I consent to massage therapy treatment *

☐ I have disclosed all relevant health information *

Client Signature *

Sign here

Date: _____

CONSENT / WAIVER

I consent to massage therapy treatment by a licensed massage therapist. I understand that massage therapy is not a substitute for medical treatment and that the therapist does not diagnose medical conditions. I have disclosed all known medical conditions, medications, and health concerns. I understand I may request to stop the session at any time. I release the therapist from liability for complications arising from undisclosed health conditions.

Client Signature: _____ **Date:** _____

Print Name: _____