Seated Massage Client Intake Form

Practioner's Name: _____ Date: _____

Location: _____

Client's Name: _____

Address: _____

City: _____ State: _____ Province: _____

Country: _____ Zip/Postal Code: _____

Telephone: _____ Fax: _____ Email: _____

Are you currently experiencing any of the following? If yes, please explain.

pain/tenderness ❑ No ❑ Yes: _____ stress ❑ No ❑ Yes: _____

numbness/tingling ❑ No ❑ Yes: _____ stiffness ❑ No ❑ Yes: _____

allergies ❑ No ❑ Yes: _____ swelling ❑ No ❑ Yes: _____

other: _____

List all illnesses, injuries and health concerns you have now or have had in the past 3 years.
(Examples: arthritis, diabetes, high blood pressure, pregnancy, recent car accident): _____

_____

List medications and pain relievers you take: _____

_____

I have provided all my known medical information. The general benefits of massage, possible massage contraindications, and the treatment procedure have been explained to me. I acknowledge that massage is not a substitute for medical diagnosis and treatment. I give my consent to receive treatment.

Signature: _____ Date: _____