Client Intake

Personal Information

Name: ______________________________ Home Phone #: ________________________________

Birthdate: ______________________________ Cell Phone #: ________________________________

Address: ______________________________ Email Address: ________________________________

____

☐ by checking here I agree to receive appointment reminders via text or email

Occupation: ____

Hobbies/activities/recreational pursuits: ____

____

Therapist use only:

Emergency Contact

Name: ______________________________ Relationship: ______________________________

Phone #: ______________________________

Massage Experience

Have you received a professional massage before? ☐ yes ☐ no

If yes, what type or types? ____

What do you like about massage? ____

What do you dislike about massage? ____

Pressure Preference? ☐ light ☐ moderate ☐ deep ☐ not sure

Therapist use only:

Medical History

Primary care physician: __________________________________ Date of last visit: ________________

Other relevant health care professionals: ____

Medications (prescribed/over the counter): ____

____

Supplements/herbs: ____

Allergies: ____

Tobacco use: How many packs per day? ______ How many years? ______ If quit, when? _________

Therapist use only:

Have you had any (if yes, please explain)

- ☐ Hospitalizations: ____
- ☐ Accidents or injuries: ____
- ☐ Surgeries: ____

Therapist use only:

Check all that apply:

Musculoskeletal

- ☐ Tendonitis/bursitis
- ☐ Arthritis
- ☐ Sprain/strain
- ☐ Fracture
- ☐ Dislocation
- ☐ Spinal disorder
- ☐ Headache/migraine
- ☐ Spasm/cramp
- ☐ TMJ
- ☐ Osteoporosis

Circulatory

- ☐ Heart condition
- ☐ Stroke/TIA
- ☐ Aneurysm
- ☐ Phlebitis/varicose veins
- ☐ Blood clot
- ☐ High/low blood pressure
- ☐ Lymphedema

Respiratory

- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Sinus problem

Nervous

- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Paralysis
- ☐ Shingles
- ☐ Numbness/tingling
- ☐ Chronic pain
- ☐ Fatigue
- ☐ Sleep disorder
- ☐ Seizure disorder
- ☐ PTSD/traumatic brain injury

Digestive

- ☐ Crohn's disease/colitis
- ☐ IBS
- ☐ GERD/reflux
- ☐ Bladder/kidney ailment

Skin

- ☐ Rash
- ☐ Rosacea/acne
- ☐ Burn
- ☐ Fungal infection
- ☐ Herpes/cold sore
- ☐ Wart

Reproductive

- ☐ Pregnant
- ☐ Endometriosis/Fibroids
- ☐ Ovarian/menstrual problems
- ☐ Prostate problem

Other

- ☐ Hepatitis A/B/C
- ☐ Fibromyalgia
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Depression
- ☐ Anxiety
- ☐ Chemical dependency
- ☐ Autoimmune disease
- ☐ Piercing/tattoo
- ☐ Contact lenses
- ☐ Dentures
- ☐ Hearing aids
- ☐ ____________________________
- ☐ ____________________________

Therapist use only:

Client agreement:

By signing below, you agree to the following:

- I acknowledge that physical/massage therapy is not a substitute for medical care, examination, and diagnosis.
- Information exchanged during a therapy session is educational in nature and is intended to help me become more familiar with my own health status and is to be used at my own discretion.
- I understand that there is no implied or stated guarantee of the effectiveness of physical/massage therapy.
- The information that I provided is accurate and complete to the best of my knowledge and I agree to inform my therapist if any of the above information changes at any time.
- Regarding minors (those under 18 years old): I give permission to treat the minor that I am responsible for and understand that I must accompany the minor during the session.
- I understand that the therapist reserves the right to refuse service or terminate a session based upon the client's condition, therapist's skill set, client attitude or client actions.
- I am aware of the risks and benefits of physical/massage therapy and give my consent for treatment.

Client signature: ____ Date: _______________

Parent/legal guardian name: _____________________________________
(if client is under 18 years old) print

Parent/legal guardian signature: __________________________________ Date: ________________
(if client is under 18 years old) sign

Therapist signature: ____ Date: ________________
Brian D. Anderson, PT, OCS, LMT

created: June 2020; revised: