RANGE
PHYSICAL THERAPY + WELLNESS

Client Intake Form - Therapeutic Massage

Personal Information:

Name: _____ Date: _____ Date of Birth _____

Phone: _____ Email: _____

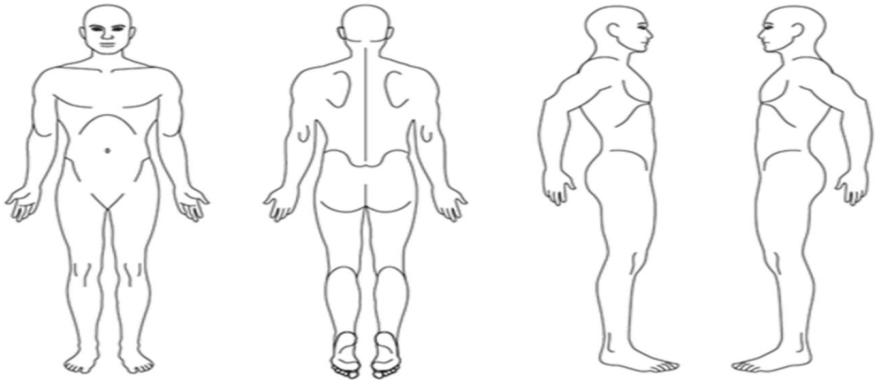
Address: _____

Occupation: _____ Emergency Contact: _____ Phone: _____

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. Do you have sensitive skin? ☐ Yes ☐ No
5. Are you wearing ☐ contact lenses ☐ dentures ☐ a hearing aid?
6. Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No
7. Do you perform any repetitive movement in your work, sports, or hobbies? ☐ Yes ☐ No
   If yes, please explain: _____
8. Do you experience stress in your work, family, or other aspects of your life? ☐ Yes ☐ No
   If yes, ☐ Muscle tension ☐ Anxiety ☐ Insomnia ☐ Irritability ☐ Other_____
9. Is there a particular area of the body you are experiencing tension, pain, or discomfort? ☐ Yes ☐ No
   If yes, please explain: _____
10. Do you have any goals in mind for this massage session? ☐ Yes ☐ No
    If yes, please explain: _____

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



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Medical History

11. Are you currently under medical supervision? ☐ Yes ☐ No

If yes, please explain_____

12. Do you see a chiropractor? ☐ Yes ☐ No

If yes, how often? _____

13. Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list: _____

_____

14. Please check any of the conditions listed below that apply to you:

☐ contagious skin condition	☐ heart condition	☐ Infection
☐ open sores or wounds	☐ deep vein thrombosis/blood clots	☐ fibromyalgia
☐ easy bruising	☐ varicose and/ or spider veins	☐ TMJ disorder
☐ osteoporosis	☐ recent accident or injury	☐ carpal tunnel
☐ epilepsy or seizure	☐ back/neck problems	☐ tennis or golf elbow
☐ recent fracture	☐ headaches/ migraines	☐ sprains/strains
☐ deceased sensation	☐ recent surgery	☐ diabetes
☐ cancer	☐ artificial joint	☐ allergies/sensitivity
☐ current fever	☐ circulatory disorder	☐ swollen glands
☐ high or low blood pressure	☐ joint disorder/ rheumatoid arthritis osteoarthritis/ tendonitis	

☐ pregnancy If yes, how many months?_____

Please explain any condition you have marked above _____

_____

15. Is there anything else about your health history that you think would be useful for your holistic health practitioner to know to plan a safe and effective massage session for you?_____

_____

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