NEUROMUSCULAR THERAPY, LLC.
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CLIENT INTAKE FORM — THERAPEUTIC MASSAGE

Personal Information:

Name: _____ Phone: _____
Address: _____
City, State, Zip: _____
Email: _____ DOB: _____ Occupation: _____
Emergency Contact: _____ Phone: _____

The following information will be used to help plan a safe and effective massage session. Please answer the questions to the best of your knowledge — please remember to bring this form with you on your first visit.

Date of Initial Visit: _____
Have you had a professional massage before? ☐ Yes ☐ No
▸ If yes, how often do you receive massage therapy? _____
Do you have any difficulty lying on your front, back or side? ☐ Yes ☐ No
▸ If yes, please describe: _____
Do you have any allergies to oils, lotions or ointments? ☐ Yes ☐ No
▸ If yes, please describe: _____
Do you have sensitive skin? ☐ Yes ☐ No
Do you wear any of the following? ☐ Contact Lenses ☐ Dentures ☐ Hearing Aid
Do you sit for long hours (e.g. workstation, computer, driving)? ☐ Yes ☐ No
▸ If yes, please describe: _____
Do you perform any repetitive movement at your work place, sports or hobby? ☐ Yes ☐ No
▸ If yes, please describe: _____
Do you experience stress in your work, family or other aspect of your life? ☐ Yes ☐ No
▸ If yes, how does it affect you? ☐ Anxiety ☐ Insomnia ☐ Irritablilty ☐ Other (please describe below)
▸ _____
Is there an area of the body where you are experiencing tension, stiffness, pain or other discomfort? ☐ Yes ☐ No
▸ If yes, please identify: _____
Do you have any particular goals in mind for this massage session? ☐ Yes ☐ No
▸ If yes, please elaborate: _____

Please check any specific areas you would like the massage therapist to concentrate on during the session:

☐ Hips
☐ Buttocks
☐ Quads
☐ Hamstrings

☐ Neck (front)
☐ Shoulders
☐ Chest
☐ Lats

☐ Lower-belly
☐ Hips
☐ Quads
☐ Hamstrings

☐ Neck (back)
☐ Upper back
☐ Lower back

☐ Feet
☐ Calves
☐ Legs (general)

☐ Hands
☐ Forearms
☐ Biceps
☐ Triceps

Medical History

In order to plan a safe and effective massage session, we need some general medical information.

Are you currently under medical supervision? ☐ Yes ☐ No

▸ If yes, please explain: _____

Are you currently under the care of a chiropractor? ☐ Yes ☐ No

Are you currently taking any medication? ☐ Yes ☐ No

▸ If yes, please list: _____

Please check any condition listed below that applies to you:

- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ easy bruising
- ☐ recent accident or injury
- ☐ recent fracture
- ☐ recent surgery
- ☐ artificial joint
- ☐ sprains/strains
- ☐ current fever
- ☐ swollen glands
- ☐ allergies/sensitivity
- ☐ heart condition
- ☐ high or low blood pressure
- ☐ circulatory disorder
- ☐ varicose veins
- ☐ atherosclerosis
- ☐ phlebitis
- ☐ deep vein thrombosis/blood clots
- ☐ joint disorder/rheumatoid arthritis/ tendonitis
- ☐ osteoporosis
- ☐ epilepsy
- ☐ headaches/migraines
- ☐ cancer
- ☐ diabetes
- ☐ decreased sensation
- ☐ back/neck problems
- ☐ fibromyalgia
- ☐ TMJ
- ☐ carpal tunnel syndrome
- ☐ tennis elbow
- ☐ pregnancy — if so, how many months? _____

Please explain any condition that you have marked above:

▸ _____

▸ _____

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

▸ _____

Important information: Draping will be used during the session; only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client: _____ Date: _____

Signature of Massage Therapist: _____