

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: _____