

# Absolute Balance Bodywork

## Confidential Client Intake Form – Therapeutic Massage

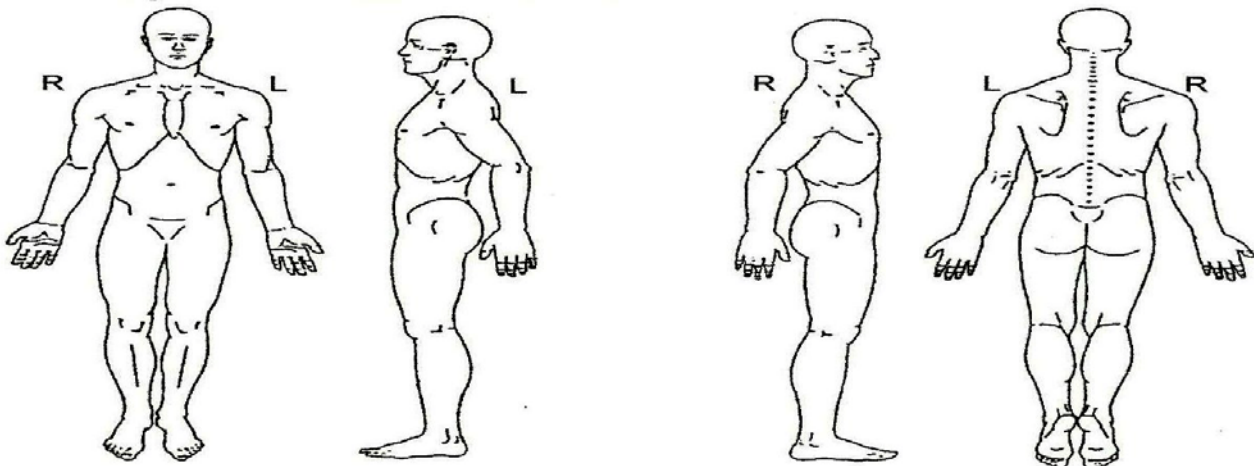
Name \_\_\_\_\_ Phone (Day) \_\_\_\_\_ Phone (Eve) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Email \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.**

Date of initial visit \_\_\_\_\_

- 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 ( ) hearing aid ( )?
- 6) Do you sit for long hours at a workstation, computer, or driving? Yes \_\_\_ No \_\_\_  
If yes, please describe \_\_\_\_\_
- 7) Do you perform any repetitive movement in your work, sports, or hobby? Yes \_\_\_ No \_\_\_  
If yes, please describe \_\_\_\_\_
- 8) Do you experience stress in your work, family, or other aspect of your life? Yes \_\_\_ No \_\_\_  
If yes, how do you think it has affected your health: muscle tension ( ) anxiety ( ) insomnia ( )  
irritability ( ) other \_\_\_\_\_
- 9) Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?  
Yes \_\_\_ No \_\_\_ If yes, please identify \_\_\_\_\_
- 10) Do you have any particular goals in mind for this massage session? Yes \_\_\_ No \_\_\_  
If yes, please explain \_\_\_\_\_

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



**Medical History : In order to plan a massage session that is safe and effective, I need some general information about your 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(s)? Yes \_\_\_\_ No \_\_\_\_  
If yes, please list \_\_\_\_\_
- 14) Please check any condition listed below that applies to you:
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> contagious skin condition   | <input type="checkbox"/> phlebitis                         | <input type="checkbox"/> open sores or wounds       |
| <input type="checkbox"/> DVT / blood clots   | <input type="checkbox"/> easy bruising                     | <input type="checkbox"/> recent accident or injury  |
| <input type="checkbox"/> joint disorder / rheumatoid arthritis / osteoarthritis / tendonitis | <input type="checkbox"/> heart condition                   |   |
| <input type="checkbox"/> recent fracture   | <input type="checkbox"/> osteoporosis                      | <input type="checkbox"/> recent surgery             |
| <input type="checkbox"/> atherosclerosis   | <input type="checkbox"/> epilepsy                          | <input type="checkbox"/> varicose veins             |
| <input type="checkbox"/> headaches / migraines   | <input type="checkbox"/> pregnancy *how many months? _____ |   |
| <input type="checkbox"/> artificial joint  | <input type="checkbox"/> cancer                            | <input type="checkbox"/> circulatory disorder       |
| <input type="checkbox"/> sprains / strains   | <input type="checkbox"/> diabetes                          | <input type="checkbox"/> tennis / golf elbow        |
| <input type="checkbox"/> current fever   | <input type="checkbox"/> decreased sensation               | <input type="checkbox"/> high or low blood pressure |
| <input type="checkbox"/> swollen glands  | <input type="checkbox"/> back / neck problems              | <input type="checkbox"/> carpal tunnel syndrome     |
| <input type="checkbox"/> allergies / sensitivity   | <input type="checkbox"/> Fibromyalgia                      | <input type="checkbox"/> TMJ                        |

Please explain any condition that you have marked above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- 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.

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I, \_\_\_\_\_ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief from 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 the massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medial 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.

Client signature \_\_\_\_\_ Date \_\_\_\_\_  
Massage Therapist signature \_\_\_\_\_ Date \_\_\_\_\_