BODHI
massage therapy

# Client Intake Form

Date _____

**Personal Information**

Name _____ Phone _____

Address_____

City/State/Zip _____

E-Mail _____ Date of Birth _____

Occupation _____ Can I add you to my mailing list? Yes No

How did you hear about me? _____

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 a massage? _____

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. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please describe _____

6. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe _____

7. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No If yes, please identify _____

8. Are you comfortable having therapeutic massage on the following areas:
   Feet ( Y / N ) Face/Head ( Y / N ) Gluteal Region ( Y / N ) Pectoral muscles ( Y / N )

9. Do you have any particular goals in mind for this massage session? If yes, please explain

_____

_____

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

10. Are you currently under medical supervision for a special medical condition? Yes No
If yes, please explain _____

11. Are you currently taking any medication? Yes No
If yes, please explain _____

12. Please check any condition listed below that applies to you, or use the blank spaces to fill in applicable conditions not listed:

| | | | |
|---|---|---|---|
| Contagious skin condition | Sprains/strains | Current fever | Recent accident/injury |
| Open Sores/Wounds | Swollen glands | Allergies/sensitivities | Recent surgery |
| Easy bruising | Headaches/migraines | Back/neck problems | Insomnia |
| Heart condition | Epilepsy | Cancer | Carpal tunnel |
| High/Low blood pressure | Diabetes | Fibromyalgia | TMJ |
| Circulatory disorder | Blood clots/clotting | Joint disorder/Arthritis | |
| Varicose veins | Pregnancy | | |
| | | | |

Please explain conditions checked _____
_____
_____

Draping will be used during the session – only the area being worked on will be uncovered.

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 and 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.

I have received a copy of the massage therapist's policies and I understand them and agree to abide by them.

All information obtained becomes part of your confidential patient file and is never shared with anyone.

Signature of Client _____ Date _____

Signature of Massage Therapist _____ Date _____