



## New Client Form

### Client Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Email \_\_\_\_\_

Phone (Cell) \_\_\_\_\_ Phone (Home) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

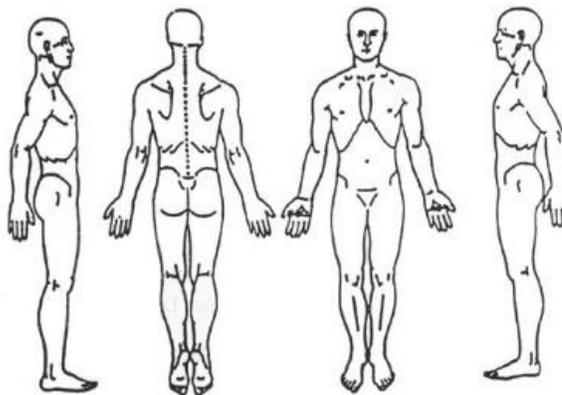
Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**To help plan a safe and effective massage session, please answer the questions to the best of your knowledge.**

1. Have you had a professional massage before? Yes  No   
If yes, when was your last one? \_\_\_\_\_ 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, essential oils, lotions, or ointments? Yes  No   
If yes, please explain \_\_\_\_\_
4. Do you have sensitive skin? Yes  No
5. Are you wearing any of the following? 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 movements in your work, sports, or hobby? Yes  No   
If yes, please describe \_\_\_\_\_
8. Do you experience stress in your work, family, or other aspects 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 experiencing tension, stiffness, pain, or other discomforts?  
Yes  No  If yes, please identify \_\_\_\_\_
10. What goals do you have in mind for this massage session? Relaxation  Stretching  Tension Release   
Other \_\_\_\_\_

**Circle any specific areas you would like the massage therapist to concentrate on during the session.**



## 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 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"/> Deep vein thrombosis/blood clots                              |
| <input type="checkbox"/> Easy bruising              | <input type="checkbox"/> Joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> Recent accident or injury  | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Recent surgery             | <input type="checkbox"/> Epilepsy  |
| <input type="checkbox"/> Artificial joint           | <input type="checkbox"/> Headaches/Migraines   |
| <input type="checkbox"/> Sprains/Strains            | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Current fever              | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Swollen glands             | <input type="checkbox"/> Decreased sensation   |
| <input type="checkbox"/> Allergies/Sensitivity      | <input type="checkbox"/> Back/Neck problems  |
| <input type="checkbox"/> Heart condition            | <input type="checkbox"/> Fibromyalgia  |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> TMJ   |
| <input type="checkbox"/> Circulatory disorder       | <input type="checkbox"/> Carpel Tunnel Syndrome  |
| <input type="checkbox"/> Varicose veins             | <input type="checkbox"/> Tennis elbow  |
| <input type="checkbox"/> Atherosclerosis            | <input type="checkbox"/> Pregnancy If yes, how many months? _____                      |
| <input type="checkbox"/> Liver disease              | <input type="checkbox"/> Kidney disease  |

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 practitioner to know to plan a safe and effective massage session for you?

\_\_\_\_\_

## Consent

I, \_\_\_\_\_, understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. Suppose I experience any pain or discomfort during this massage session, I will immediately inform the therapist. Only then can the therapist know to make proper adjustments to meet my comfort level. I understand that massage should not be construed as a substitute for a medical examination, diagnosis, or treatment. I should see a physician, chiropractor, or other qualified medical specialists for any mental or physical ailment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. Because massage therapy may not be recommended for certain medical conditions, I have stated all my known medical conditions and honestly answered all questions. I agree to keep the therapist updated regarding 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 understand that any illicit or sexually suggestive remarks or advances made by me will immediately terminate the session. I also understand that the massage therapist reserves the right to immediately terminate massage or decline services if they deem I have a condition for which massage is not recommended. I understand massage therapy involves maintained touch and close physical proximity over an extended time. Because of this, there may be an elevated risk of disease transmission, including COVID-19.

Client Signature \_\_\_\_\_ period \_\_\_\_\_ Date \_\_\_\_\_

Massage Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_