Appendix 31 – Client Intake Form Samples

- Please note that these are samples, and that it is up to the therapist or clinic owner to adapt or draft their own client intake form.

Sample 1

Client Intake Form – Therapist Name, Designation(s)

Welcome! Please complete this information to help the therapist get to know you and so your therapy can be customized to your needs. This information is confidential and will only be used in the development of your massage therapy treatment plan. If an outside party requests this information, it will be released only after written permission is obtained from you, the client, or through a court order.

General Information

Name _____ Date _____

Mailing Address _____ City _____

Province _____ Postal Code _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Occupation _____ Employer _____

Emergency Contact _____ Phone Number _____

Medical / Health History

Please mark an (X) by all current conditions and (P) for all past conditions:

__ Abdominal/Digestive Problems	__ Contagious Skin Condition	__ Muscle Spasms or Cramping
__ Allergies- If yes please specify:	__ Current Fever	__ Numbness/Tingling
_____	__ Decrease Sensation	__ Open Sores or Wounds
_____	__ Depression	__ Ovarian/Menstrual Problems
_____	__ Diabetes	__ Osteoporosis
__ Aneurysm	__ Diverticulitis	__ Pinched Nerve
__ Anxiety	__ Eating Disorders	__ Pregnancy
__ Arm/Hand Pain	__ Epilepsy	__ Rash/Fungus
__ Arthritis/tendonitis	__ Fibromyalgia	__ Scoliosis
__ Artificial Joint	__ Headaches, Migraine	__ Seizures
__ Atherosclerosis	__ Hearing Problems	__ Shingles
__ Asthma or lung condition	__ Heart Attack	__ Sinus Problems
__ Athletes foot/Warts	__ Heart Condition	__ Sleep Difficulties/Disorders
__ Back or Neck Problems	__ Hepatitis (A, B, C, other)	__ Spinal Disorders
__ Bladder or Kidney Ailment	__ Hernia	__ Sprain/Strain
__ Blood Clots	__ Herpes/cold sores	__ Stroke
__ Blood Pressure: o Low o High	__ HIV/AIDS	__ Swollen Glands
__ Bone or Joint Disease	__ Irritable Bowel Syndrome	__ Tennis Elbow
__ Bruise Easily	__ Liver Disease	__ Tension/Stress
__ Cancer	__ Lupus	__ Thyroid Problems
__ Carpal Tunnel Syndrome	__ Lymphedema	__ Ulcers
__ Chemical Dependency (Alcohol, Drug)	__ Jaw Pain/ TMJ pain	__ Undiagnosed Acute Pain
__ Chronic Fatigue	__ Joint Dislocations	__ Vision Problems
__ Chronic Pain	__ Mental/Psychological Condition	__ Varicose Veins
__ Circulatory/Heart Problems	__ Muscle/Bone Injuries	__ Whiplash
__ Constipation/ Diarrhea	__ Muscle/Joint Pain	__ Other (describe below)

Are there any other medical conditions that you have which are not listed above that we should know about? _____

_____

Injuries, accidents or illnesses that are still affecting you: _____

_____

Do you wear contact lenses or glasses: o Yes o No Recent Surgery? o Yes o No

How would you rate your state of health? o Excellent o Good o Fair o Poor

Height _____ Weight _____ Family Doctor _____

Please list any current medications you are taking: _____

_____

Do you have any of the following today: o Skin Rash o Cold/Flu o Open Cuts o Severe Pain o Anything Contagious o Bruises/Injuries

Do you have any allergies to oils, lotions, or ointments? o Yes o No If yes please explain: _____

_____

Please turn page over and complete the other side.

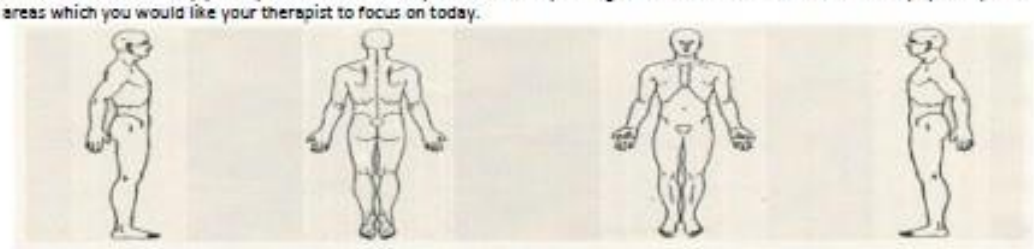
Client Intake Form – Therapist Name, Designation(s)

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? _____

_____

Massage Session Information

Please indicate with an (X), if any, the areas in which you are currently feeling discomfort. Please indicate with an (M), if any, the areas which you would like your therapist to focus on today.



What results are your goals/expectations for this massage therapy session? _____

_____

Do you have any concerns about getting a massage today? _____

_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: need to move or change position, sighing, yawning, change in breathing, stomach gurgling, emotional feelings and/or expression, movement of intestinal gas, energy shifts, falling asleep, memories.

Consent

Please read the following information and sign below:

1. I understand that the therapist has informed me his credentials, and has informed me of treatment costs, and my financial obligations.
2. I understand that it is my choice to receive massage therapy, and receive it at my own risk.
3. I understand that massage therapy is beneficial for relaxation, relief from pain, tension, and stress and increase in circulation.
4. I understand that massage therapists do not preform medical examination, diagnose illness, disease or mental disorders; nor do they prescribe any medical treatment, pharmaceuticals, or perform any spinal manipulation, and that it is recommended that I see my physician for any ailment that I may have.
5. I understand that I am responsible to inform my therapist at each visit of any changes to my health.
6. I have truthfully stated all medical and health conditions that I am aware of, and this information is accurate to the best of my knowledge.
7. I understand that not informing the therapist of critical health information could result in injury due to contraindications for massage. I understand that massage is contraindicated for some medical conditions and that obtaining a medical clearance or prescription may be necessary before beginning treatment.
8. I understand that draping will be used during the session and that only the area being worked on will be uncovered.
9. I will, if I experience any pain or discomfort during the massage, immediately inform my massage therapist so that the pressure and/or methods can be adjusted to my comfort level.
10. I understand that this is a therapeutic massage, and that any sexual advances, request for sexual favors, or other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will terminate the session, and that I will be liable for full payment of the scheduled treatment.
11. I understand that if the massage therapist starts a session late, they will make it up to me at the end of my session, if possible, or will reduce my fee accordingly. I understand that if I arrive late, my session will end at the originally scheduled time so the client following me is not penalized.
12. I agree to give 24 hour notice for a scheduled session that I cannot keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24 hour notice to cancel or reschedule.
13. In the event that I become injured, either directly or indirectly, as a result, in whole or in part, of the aforesaid massage therapy, I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Name: _____ Signed: _____ Date: _____

Relationship to minor being treated (if applicable) _____

Please turn page over and complete the other side.

Sample 2

Add business contact information here

CONFIDENTIAL CLIENT INFORMATION

Name _____ Phone (home) _____

Birthdate _____ Phone (work) _____

Address _____ Phone (cell) _____

City _____ Province _____ Postal Code _____

Email: _____

Occupation _____ Employer _____

Referred by: _____

Medical History (list present/ previous illnesses, conditions, accidents, surgeries, fractured bone, etc. Please include dates)

_____

_____

_____

_____

What sporting/ exercise activities are you involved in: _____

_____

Please list current medications: _____

_____

_____

Medical Doctor: _____ Chiropractor: _____

Physiotherapist: _____ Other Health Professionals: _____

Previous Massage Experience: Y ☐ N ☐ Comments: _____

Purpose of this Appointment (Major Complaint): _____

_____

When did these symptoms appear: _____

Have you ever had same or similar conditions? Y o N o If yes, when and describe: _____

_____

How is this condition interfering with your daily routine? _____

_____

Is it progressively getting worse? Y ☐ N ☐ Constant? Y ☐ N ☐ Comes & Goes? Y ☐ N ☐

What makes it worse? _____

What makes it better? _____

Other complaints: _____

Confidential Health History

In order to protect yourself, your therapist, and others, honest disclosure is essential.

Head/ Neck:

headaches
- tension
- migraine

whiplash
TMJ
vision problems
contact lenses
earaches
hearing problems
sinus problems

Respiratory:
rib injuries
breathing difficulties

Cardiovascular:
high blood pressure
low blood pressure
phlebitis
dizziness
heart disease
varicose veins
blood clots
circulation problems

Skin:
allergies
bruise easily
other _____

Muscles/ Joints:
pain _____
sprains
strains
spasms
tears
numbness/ tingling
bursitis
tendonitis
arthritis _____

Digestive:
constipation
diarrhea
gas
digestion problems :
_____
other _____

Skeletal:
broken bones : _____
_____
osteoporosis
date of diagnosis:
_____
spinal condition

Cancellation Policy

Your appointment time is reserved especially for you. Any cancellations or rescheduling must be done with a minimum of six (6) business hours, or you will be charged the cost of your appointment. Thank you for your co-operation and understanding.

I understand that the information I have given on this form will be confidential and will be used for no other purposes than the therapist's records, and/ or for the emailing/ mailing of timely reminders. The contents of this form and related documents are the property of the therapist. I also verify that the above information is correct and complete.

Signature: _____ Date: _____