# Illusions Client Intake Form- Therapeutic Massage

**Personal Information:**

Name_____ Best Contact Number_____ **Date of Service**_____

Address_____City/State/Zip_____

Email_____ Date of Birth_____

Occupation_____ Emergency Contact_____Phone_____

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

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?_____

   If yes, please explain_____

3. Do you have any allergies to oils, lotions, or ointments?_____

   If yes, please explain_____

4. Do you have sensitive skin? YES NO

5. Are you wearing contact lenses?_____

6. Do you sit for long hours at a workstation, computer, or driving?_____

7. Do you preform any repetitive movement in work, sports, or hobbies?_____

   If yes, please explain_____

8. Do you experience stress with work, family, or other aspects of life?_____

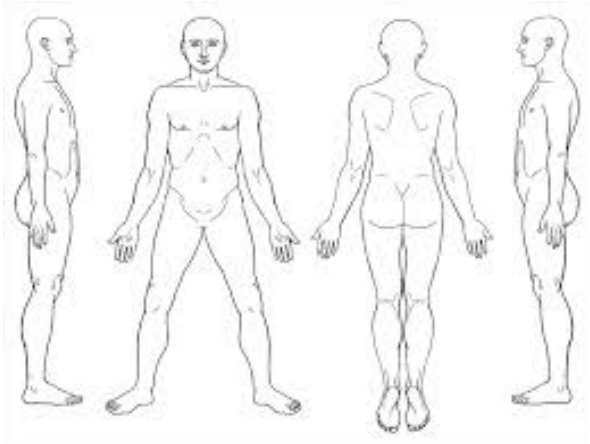
   If yes, how do you think it has affected your health?_____

   Muscle tension ( ) Anxiety ( ) Insomnia ( ) irritability ( ) Other_____

9. Is there any area of the body where you are experiencing tension, stiffness, pain, or other discomfort YES NO

   If yes, please explain_____

**Please circle any areas you wish the therapist to focus on during this session**



**Illusions Client Intake Form- Therapeutic Massage (continued)**

10. Are you currently under any medical supervision? YES NO

11. Do you see a chiropractor? YES NO If yes, how ofter?_____

12. Are you currently taking any medications? YES NO

If yes, please explain_____

13. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) artificial joint
( ) recent fracture
( ) recent surgery
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivities
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorders/arthritis
( ) osteoporosis
( ) epilepsy
( ) headache/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy if yes, how many months?_____

Please explain any condition you have listed above

_____

_____

14. Is there anything else about your medical 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 this 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 / strokes may be adjusted to my level of comfort. I further understand that massage should not be continued as a substitute for medical examination, diagnosis, or treatment and that I should seek appropriate medical treatment for any physical ailment that I am aware of. I understand that massage therapists are not qualified to perform any spinal or skeletal adjustments, diagnose, prescribe, or treat any physical illness. I affirm that I have stated all my known medical conditions and all the questions truthfully and to the best of my knowledge. I agree to keep the therapist undated to any changes to my medical profile and understand that there should be no liability on the therapist / establishment should I fail to do so.

Signature of client_____Date_____

Signature of therapist_____Date_____