Brookview WELLNESS
HOLISTIC CHIROPRACTIC CARE

Massage Therapy Intake Form

Date of Initial Visit:

Name: _____ Phone: _____DOB: _____

Address: _____ City/State/Zip: _____

Email: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

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

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 sit for long hours? (workstation, driving, computer) Yes No

4. Do you perform any repetitive movements? Yes No
   If yes, please explain.

5. Do you have sensitive skin? (thin skin, easily bruise, etc.) Yes No
   If yes, please explain.

6. Do you have any known allergies? Yes No
   If yes, please explain.

7. What areas of your body are you experiencing pain, tension, stiffness, or other discomfort?

8. What type of massage are you seeking? Relaxation Therapeutic

9. What pressure do you prefer? Light Medium Firm/Deep

10. Circle below which areas you would like to have massaged.

    Scalp Face Pectoral Abdomen Glutes Feet

Medical History

1. Are you currently under a medical doctor's care? Yes No
   If yes, please explain.

2. Do you currently take any medication? Yes No
   Please list medication.

3. Check all conditions below that apply to you:

( )Fever, cold, or flu	( )Cancer-past or present
( )Heart condition	( )Osteoporosis
( )Recent surgery	( )Recent fracture
( )Joint disorder/tendonitis	( )Artificial joint
( )Diabetes	( )Open sore or wound
( )Skin condition	( )TMJ
( )Deep vein thrombosis	( ) High or low blood pressure
( )Pregnancy-If yes, how many months?	

Please explain the conditions you have checked above:

4. Is there anything else about your health history you think would be useful for the massage therapist to know about?

Draping will be used during the massage sessions- 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 relief of muscular tension or relaxation. If I experience any pain or discomfort during this session or future sessions with the therapist, I will immediately inform the therapist, so 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 qualified medical physician or chiropractor for any physical or mental ailment that I am aware of. I understand that massage therapists are not qualified to perform skeletal adjustments, diagnose, prescribe, or treat any mental or physical illness, and that nothing said during the session should be construed as such. I understand that 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: _____