

Massage Therapy Client Intake Form

Revised 9/2/2021

Client Information

*Last Name**First Name**M.I.**Date of Birth*

*Street Address**City**State**ZIP Code*

*EEmail**Phone #*

*How did you hear about us?***Please answer the following questions to the best of your ability.**

1. Are you allergic or sensitive to any oils?	• Yes	• No
2. Are you allergic or sensitive to fragrance in massage oils?	• Yes	• No
3. Has your doctor prescribed massage therapy for health reasons?	• Yes	• No
4. Do you take any prescribed medication?	• Yes	• No
5. Have you had surgery within the past year?	• Yes	• No
6. Do you have varicose veins or blood clots?	• Yes	• No
7. Do you have arthritis?	• Yes	• No
8. Do you have any heart problems?	• Yes	• No
9. Do you have blood pressure problems?	• Yes	• No
10. Do you have physical tension due to a car accident or any other accident (lifting, falling, etc.)?	• Yes	• No
11. Do you have physical tension due to a sports injury?	• Yes	• No

Do you now have or ever have had any of the following?

- Non-Union Fractures
- Cancer
- Phlebitis
- Spastic Paralysis
- Headaches
- Insomnia
- Stiff Neck
- Constipation
- Skin Diseases
- Contagious Diseases

Is there pain present? _____ If so, where? _____

Please provide us any further information that would be helpful for your massage:

_____**Assumption of Risk**

I hereby acknowledge that I am fully aware that there are risks inherent in my participation in and preparation for massage therapy services, and I willingly and voluntarily assume such risks. Risks may include physical and/or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability, death or economic

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loss. These injuries or outcomes may arise from my own or other's actions, inactions, or negligence, or the condition of the activities location or facility. Nonetheless, I assume all risks of my participation in this massage therapy, whether known or unknown to me, or any events incidental to this activity.

Print Name: _____

Date: _____

Signature: _____

INFORMED CONSENT

I understand that massage therapists are not licensed to practice medicine and therefore do not diagnose illness or disease; perform spinal manipulations; or prescribe medical treatments. I am aware that massage therapy is not a substitute for medical treatment, medication or diagnosis for any health condition I may have. It is recommended that I pursue appropriate health management for condition I may have. Due to certain contraindications and cautions for massage, the practitioner must be made aware of existing physical and mental conditions. I have informed the massage therapist of all my known physical and medical conditions, and medications. I understand that it is my responsibility to keep the massage therapist updated on any changes in my health status and agree to do so each time I receive massage.

Client Name (Print): _____

Date:

Client Signature: _____

My physical or electronic signature attests that I have received the Complementary and Alternative Health Care Bill of Rights.

Client Name (Print): _____

Date: _____

Client Signature: _____

If you have any questions on the above information, please direct them to Nate Kubik, Massage Therapy Coordinator, kubik028@umn.edu or (612)-626-2567.