AFFILIATED THERAPY GROUP PRACTICE, INC.

MASSAGE CLIENT INTAKE FORM

Name: First_____Last_____

Address:_____

City_____ Zip_____

Email address (to receive promotions and specials):_____

Phone: Daytime_____Home_____Cell_____

DOB_____Occupation:_____

Referred By_____

Emergency Contact: _____Phone_____

Physician:_____Phone_____

MASSAGE INFORMATION

CHECK ALL THAT APPLY		Heart Trouble	
Allergies to oil or lotion		High Blood Pressure	
Arthritis		Low Blood Pressure	
Bursitis		Migraine Headaches	
Cancer		Phlebitis	
Diabetes		Varicose Veins	
Epilepsy		Skin Disorder	
Infectious Disease		Tense Muscle	
Impetigo			
BODY PARTS TO BE MASSAGED			
Head		Arms	
Back		Face	
Buttock		Hands	
Legs		Abdomen	
Shoulders		Upper Chest	
Feet		Neck	

ATHGP

Is this your first professional massage: ◊Yes ◊No

If no, how frequently do you have a massage?_____

Have you had any recent surgeries? ◊ Yes ◊ No

If yes, when and what type?_____

Are you currently pregnant? ◊ Yes ◊ No

If yes, how many weeks?_____

Have you had any recent trauma or injury? ◊ Yes ◊ No

If yes, when and what type?_____

Areas of complaint, pain or tension:_____

Areas you wish to be avoided:_____

Preferred pressure? (Please circle one) light moderate deep

PLEASE READ AND INITIAL THE FOLLOWING:

I am responsible for any valuable items I bring into the massage room with me._____

Breast massage will not be performed on female clients without prior consent._____

Proper draping procedures are required to protect the modesty of the client and the therapist._____

If I am uncomfortable for any reason, I may request to end the session._____

I, _____, understand that the massage given is for stress reduction and increased circulation and is not to be used in the place of medical treatment. It is recommended I seek a physician for any medical problems that I may have. To the best of my knowledge, all of the information regarding my state of health and medical history is correct. I also understand that a missed appointment might incur charges that I must pay.

Client Signature_____Date_____

Therapist Signature_____Date_____