# Oasis Body Therapies

## Client Intake Form- Therapeutic Massage

**Personal Information**

| IN CASE OF EMERGENCY | | | |
|---|---|---|---|
| Name of a local friend or relative(not living with you) | Relationship to patient | Home Phone | Work Phone |
| | | | |

| | |
|---|---|
| Last Name: | First Name: |
| Phone: | Date Of Birth: |
| Address: | |
| City/State/Zip | |
| Occupation: | |

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

Physician Name: ________________________ Number:____________________________ Permission to contact? Y/N

Have you had a professional massage before? Y/N Do you have sensitive skin? Y/N

Do you have any allergies to oils, lotions, or ointments? Y/N If yes, Please explain_____________________________________

Do you have any difficulty lying on your front, back, or side? Y/N If yes, Please explain _________________________________

Are you wearing: Contact lenses ( ) Dentures ( ) a hearing aid( )?

Do you sit for long hours at a workstation, computer, or driving? Y/N If yes, please explain_____________________________

Do you perform any repetitive movement in your work, sports, or hobby? Y/N If yes, please explain

_____________________________________________________________________________________________

Do you experience stress in your work, family, or other aspect of your life? Y/N If yes, how do you think this affects your health? ( ) muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) Other____________________________________________

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Y/N

If yes, please identify _________________________________________________________________________________

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

Are you currently under medical supervision? Y/N If yes, please explain

____________________________________________________________________________________________

Do you see a chiropractor? Y/N If yes, how often? _____________________________________________________________

Are you currently taking and medication? Y/N Please list _________________________________________________________

Over ☞

Please check any condition that applies to you below

- Contagious skin condition
- Open sores or wounds
- Joint disorder
- Swollen glands
- Osteoporosis
- Epilepsy
- Headaches/migraines
- Cancer
- Diabetes
- Decreased sensation
- Back/neck problems
- Fibromyalgia
- TMJ
- Carpal tunnel syndrome
- Tennis elbow
- Pregnancy if yes how many months? _____________
- Phlebitis
- Deep vein thrombosis/blood clots
- Easy bruising
- Recent accident or injury
- Recent fracture
- Recent surgery
- Artificial joint
- Sprains/strains
- Current fever
- Atherosclerosis
- Joint replacement Which?___________________
- Heart condition
- High or low blood pressure
- Circulatory disorder
- Varicose veins

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?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Because 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 the therapist updated as to any changes in my medical profile and understand there will be no liability on the therapist's part if I should fail to do so.

Signature of Client:________________________________________________ Date: ________________________________

Signature of LMT:___________________________________________________ Date: ________________________________

Massage Therapist Notes: