SOZO
Health & Physical Therapy

Client Intake – Cash Therapeutic Massage

Personal Information:

Name _____ Phone _____

Address _____Date of Birth _____

Emergency Contact _____ Phone _____

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

Date of initial visit _____ How were you referred? _____
Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? _____
Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain _____
Do you have any allergies to oils, lotions, or ointments? Yes No

If yes, please explain _____
Do you have sensitive skin? Yes No

Are you wearing any of the following? Contact lenses dentures hearing aids
Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe _____
Do you perform any repetitive movements in your work, sports, or hobby? Yes No

If yes, please describe _____
Do you experience stress in your work, family, or other aspects of your life? Yes No

If yes, do you think it has affected your health? Yes No
Does muscle tension cause any of the following? Anxiety Insomnia Irritability?

If Yes, please explain: _____

Is there a particular part of your body where you are experiencing tension, stiffness, pain, or other discomfort? Yes No

If yes, please describe _____
Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain _____

SOZO
Health & Physical Therapy

List any specific areas you would like the massage therapist to focus on during the session: _____

_____

Medical History
In order to plan a massage session that is safe and effective we need some general information about your medical history

Are you currently under medical supervision? Yes No

If yes, please explain _____

Do you see a chiropractor? Yes No

If yes, how often? _____
Are you currently taking any medication? Yes No

If yes, please list _____

Please check any condition listed below that applies/has applied to you:

- ☐ Contagious skin condition
- ☐ Open sores or wounds
- ☐ Phlebitis
- ☐ Epilepsy
- ☐ Easy Bruising
- ☐ Recent accident or injury
- ☐ Recent Fracture
- ☐ Recent Surgery
- ☐ Tennis Elbow
- ☐ Joint disorder
- ☐ Arthritis
- ☐ Cancer (currently under chemo?) Yes No
- ☐ Artificial joint
- ☐ Sprains/Strains
- ☐ Current Fever
- ☐ Swollen Glands
- ☐ High or Low Blood Pressure
- ☐ Allergies/sensitivities
- ☐ Heart Condition
- ☐ Varicose veins
- ☐ Circulatory Disorder
- ☐ Atherosclerosis
- ☐ Pregnancy (if yes how many months? _____
- ☐ Headaches/Migraines
- ☐ Osteoporosis
- ☐ Deep Vein Thrombosis
- ☐ Blood clots
- ☐ Diabetes
- ☐ Tendonitis
- ☐ Decreased Sensation
- ☐ Back or Neck Problems
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ Carpal Tunnel Syndrome joint disorder

Please explain any condition you marked above _____

_____

_____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage for you?

If yes, please explain _____

_____

SOZO
Health & Physical Therapy

I, _____ 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 and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all question 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.

Signature of client: _____ **Date:** _____