

# AMY YAPLE, L.P.N./ L.M.T.

## CLIENT INTAKE FORM- THERAPEUTIC MASSAGE

NAME: \_\_\_\_\_  
PHONE: \_\_\_\_\_ PHONE: \_\_\_\_\_  
(Day) (Evening)  
ADDRESS/CITY/STATE/ZIP: \_\_\_\_\_  
EMAIL: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
EMERGENCY CONTACT/PHONE NUMBER: \_\_\_\_\_

**THE FOLLOWING INFORMATION WILL BE USED TO HELP PLAN SAFE AND EFFECTIVE MASSAGE SESSIONS. PLEASE ANSWER THE QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.**

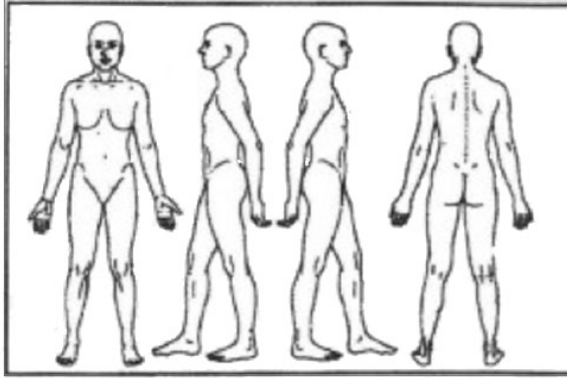
**IN ORDER TO PLAN A MASSAGE SESSION THAT IS SAFE AND EFFECTIVE, I NEED SOME GENERAL INFORMATION ABOUT YOUR MEDICAL HISTORY.**

Date of initial visit: \_\_\_\_\_

- 1.) Have you had a professional massage before? **YES** or **NO**  
If so, how often do you receive massage therapy? \_\_\_\_\_
- 2.) Do you have any difficulty lying on your front, back, or side? **YES** or **NO**  
If yes, please explain: \_\_\_\_\_
- 3.) Do you have any allergies to oils, lotions, or ointments? **YES** or **NO**
- 4.) Do you have sensitive skin? **YES** or **NO**
- 5.) Are you wearing: Contact lenses: **YES** or **NO** Dentures: **YES** or **NO** A hearing aid: **YES** or **NO**
- 6.) Do you perform any repetitive movement in your work, computer, driving? **YES** or **NO**
- 7.) Do you perform any repetitive movement in your work , sports or hobbies? **YES** or **NO**
- 8.) Do you experience stress in your work, family, or other aspect of your life? **YES** or **NO**  
If yes, how do you think it has affected your health? **CIRCLE ONE:**  
Muscle Tension- Anxiety- Insomnia- Irritability- Other: \_\_\_\_\_
- 9.) Is there a particular area of the body where you are experiencing tension, stiffness, pain or other pain or discomfort? \_\_\_\_\_
- 10.) Do you have any particular goals in mind for this massage session? **YES** or **NO**  
If yes, please explain: \_\_\_\_\_
- 11.) Are you currently under medical supervision? **YES** or **NO**  
If yes, please explain: \_\_\_\_\_

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Circle any specific areas you would like the massage therapist to concentrate on during the session.



12.) Do you see a chiropractor? **YES** or **NO** If yes, how often: \_\_\_\_\_

13.) Are you currently taking any medication? **YES** or **NO**  
If yes, please list: \_\_\_\_\_

14.) Please check any condition listed below that applies to you:

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> Contagious Skin Condition | <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> High/ Low Blood Pressure | <input type="checkbox"/> Joint Disorder/<br>Rheumatoid Arthritis | <input type="checkbox"/> Decreased Sensation                        |
| <input type="checkbox"/> Open sores                | <input type="checkbox"/> Sprains                | <input type="checkbox"/> Circulatory Disorder     | <input type="checkbox"/> Osteoarthritis/<br>Tendonitis           | <input type="checkbox"/> Back/ Neck Problems                        |
| <input type="checkbox"/> Open wounds               | <input type="checkbox"/> Strains                | <input type="checkbox"/> Varicose Veins           | <input type="checkbox"/> Osteoporosis                            | <input type="checkbox"/> Fibromyalgia                               |
| <input type="checkbox"/> Easy Bruising             | <input type="checkbox"/> Current Fever          | <input type="checkbox"/> Atherosclerosis          | <input type="checkbox"/> Epilepsy                                | <input type="checkbox"/> TMJ  |
| <input type="checkbox"/> Recent accident or injury | <input type="checkbox"/> Swollen Glands         | <input type="checkbox"/> Phlebitis                | <input type="checkbox"/> Headaches/<br>Migraines                 | <input type="checkbox"/> Carpel Tunnel<br>Syndrome                  |
| <input type="checkbox"/> Recent Fracture           | <input type="checkbox"/> Allergies/ Sensitivity | <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Cancer                                  | <input type="checkbox"/> Tennis Elbow                               |
| <input type="checkbox"/> Recent Surgery            | <input type="checkbox"/> Heart Condition        | <input type="checkbox"/> Deep Vein Thrombosis     | <input type="checkbox"/> Diabetes                                | <input type="checkbox"/> Pregnancy, If yes,<br>How may months?_____ |

PLEASE EXPLAIN ANY CONDITIONS THAT YOU HAVE MARKED ABOVE:

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15.) 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?

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Draping will be used during the session-only the area being worked on will be uncovered.  
Clients under age 17 must be accompanied by a parent or legal guardian during the entire session.

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Informed written consent must be provided by parent or legal guardian for any client under the age of 17. I, \_\_\_\_\_ (print, name) 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 medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist 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 given 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 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.

Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Massage Therapist: \_\_\_\_\_