GLOW, LLC Client Intake Form – Massage Therapy

Personal Information:

Name____ Date of Visit ______________

Phone (home) ______________ (mobile) ____________ Email ___________________________

Address ____

City/State/Zip ____

Date of Birth ____________________________ Occupation ___________________________

Emergency Contact ___________________________________ Phone ___________________

How would you prefer to be contacted for appointment confirmations or cancellations? ________

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

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 contact lenses ( ) dentures ( ) a hearing aid ( ) ?

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe. ____

Do you perform any repetitive movement 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, how do you think it has affected your health? ______________________________

muscle tension ( ) anxiety ( ) insomnia ( ) irritability ( ) other ____________________

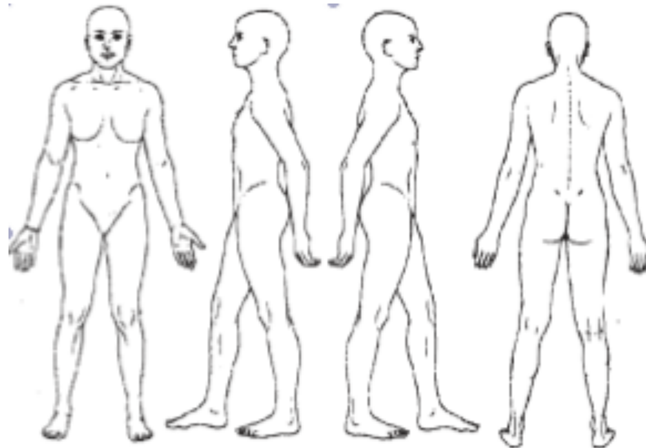
Is there an area where you are experiencing tension, stiffness, pain, or discomfort? Yes No

If yes, please identify. ____

Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain. ____

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



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Medical History

General information about your medical history is helpful in planning a massage session that is safe and effective.

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 medications? Yes No

If yes, please list. ____

Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( )back/neck problems
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/tendonitis
( ) osteoarthritis
( ) osteoporosis
( ) rheumatoid arthritis
( ) headaches/migraine
( ) epilepsy
( ) diabetes
( ) cancer
( ) decreased sensation
( ) fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?

Please explain any condition that you have marked above.

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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.
Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

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 GLOW, LLC or 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.

GLOW Cancellation Policy: 24 hour notice is required for any appointment cancellations or changes. With the exception of unexpected illness, full payment is expected for missed appointments with less than 24 hours notice.

Payment Policy: Full payment is required at time of service

Signature of Client ______________________________________ Date ________

Signature of Massage Therapist ______________________________ Date ________