Therapeutic Massage, Client Intake Form
Katie Mogg LMT

Personal Information:

Name____Phone________________________________
Occupation______________________________________Date of Birth___________________________
Address____
City/State/Zip____
Emergency Contact________________________________Phone________________________________

Medical Information:

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
( ) recent accident/injury
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) allergies/sensitivities
( ) heart condition
( ) diabetes
( ) carpal tunnel syndrome
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/osteoarthritis
( ) osteoporosis
( ) tendinitis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) back/neck problems
( ) Fibromyalgia/ nerve condition
( ) TMJ
( ) tennis elbow
( ) pregnancy – If yes, how many months?____________________

Please explain any condition that you have marked above, or any condition not listed that you may have

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I,____(print name) understand that the massage I receive is provided for the purpose of relief of muscular tension and relaxation. 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 ailments 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 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 Therapist____**Date**______________