

Massage Client Intake Form

Please fill in before your first session. Your answers help your therapist keep the massage safe.

CLIENT DETAILS

Full name

Phone

Email

Birthday

Emergency contact (name & phone)

Preferred contact ☐ Call ☐ Text ☐ Email

OK to send reminders ☐ Yes ☐ No

HEALTH HISTORY

Do you have, or have you had, any of these? Tick all that apply.

☐ High or low blood pressure

☐ Heart condition

☐ Blood clots / DVT

☐ Varicose veins

☐ Diabetes

☐ Epilepsy

☐ Osteoporosis

☐ Arthritis

☐ Cancer (current or past)

☐ Headaches or migraines

☐ Numbness or tingling

☐ Skin condition or rash

☐ Recent injury

☐ Recent surgery

☐ Pregnancy

Details of anything ticked above (when, where, how it affects you)

Medication (including blood thinners and pain relief)

Allergies or sensitivities (oils, nut oils, lotions, fragrance, latex, other)

Currently under a doctor's or physio's care? ☐ Yes ☐ No

If yes, what for



Massage Preferences & Session Notes

Goals, pressure and focus areas, signed consent, and SOAP notes for every session.

Client name

GOALS & PREFERENCES

Goals ☐ Relaxation ☐ Pain relief ☐ Stress ☐ Sports recovery ☐ Mobility

Pressure ☐ Light ☐ Medium ☐ Firm ☐ Deep Massage before? ☐ Yes ☐ No

Areas to focus on:

☐ Head / face ☐ Neck ☐ Shoulders ☐ Upper back ☐ Lower back
☐ Arms / hands ☐ Hips / glutes ☐ Legs ☐ Feet ☐ Full body

Areas to avoid, and anything else your therapist should know

CLIENT CONSENT

*My answers are correct to the best of my knowledge, and I'll tell my therapist about any changes to my health.
I understand massage is not a substitute for medical care, and I can ask to change the pressure or stop at any time.*

Client signature

Date

SESSION NOTES (SOAP)

Date	S · client reports	O · what you found	A · treatment & response	P · next time

