

THE MESSAGE CLINIC

Confidential Clinical Record — Client Intake Form

Please complete all sections. Your information is kept private and secure.

CLIENT INFORMATION

Full Name	Date of Birth	Today's Date	
Street Address			
City	State	Zip	Sex
Phone	Email		
Occupation	Emergency Contact		
Emergency Phone	Relationship		

REFERRAL INFORMATION

Were you referred by a healthcare provider? ☐ Yes ☐ No

Provider / Physician Name	Practice or Clinic
Reason or Diagnosis Given (if known)	How Did You Hear About Us

REASON FOR TODAY'S VISIT

Primary Concern

When Did It Begin	Caused By	Discomfort Level (0-10)
What Makes It Better	What Makes It Worse	

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HEALTH HISTORY (CHECK ALL THAT APPLY)

Health history helps your therapist keep your session safe and effective.

- | | | |
|--|---|---|
| ☐ Heart condition | ☐ High blood pressure | ☐ Low blood pressure |
| ☐ Blood clots / DVT | ☐ Stroke | ☐ Circulatory issues |
| ☐ Diabetes | ☐ Cancer (current or past) | ☐ Arthritis |
| ☐ Osteoporosis | ☐ Fibromyalgia | ☐ Chronic pain |
| ☐ Recent fracture | ☐ Numbness or tingling | ☐ Swelling / edema |
| ☐ Varicose veins | ☐ Skin condition | ☐ Allergies |
| ☐ Headaches / migraines | ☐ Neck or back injury | ☐ Joint replacement |
| ☐ Pregnancy | ☐ Asthma | ☐ Seizures |

Current Medications

Allergies (including oils, lotions, latex)

Recent Surgeries or Injuries

If Pregnant, Weeks

Anything Else We Should Know

AREAS OF DISCOMFORT

Mark the areas where you feel discomfort. Use O for ache, X for sharp pain.

Notes

CONSENT

I understand that massage therapy is provided for therapeutic and general wellbeing purposes. It is not a substitute for medical diagnosis or treatment. I have disclosed my health history accurately and will inform my therapist of any changes. I understand I may stop a session at any time, and that draping and professional boundaries are maintained throughout. I consent to treatment under these terms.

Client Signature (type full name to sign)

Date