A STEP BEYOND MASSAGE THERAPY

Client Intake Form

Name____ Date________________________

Are any of your joints painful when moving them? Yes No
If yes, please explain____

If this is a return visit, have any of these conditions changed since your last massage?

- ◻ High blood pressure
- ◻ Pregnancy / painful menstration
- ◻ Thrombosis/Phlebitis
- ◻ Localized infections/ open wounds
- ◻ Fracture(s) / painful joints
- ◻ Skin problems / rash
- ◻ Headaches
- ◻ Trauma / wounds
- ◻ Varicose veins
- ◻ Bruising
- ◻ Swelling
- ◻ Fever
- ◻ Medications
- ◻ Illness / Diseases
- ◻ Injuries
- ◻ Nut Allergy

If you checked any of the above conditions or if you have a condition not listed above, please explain:

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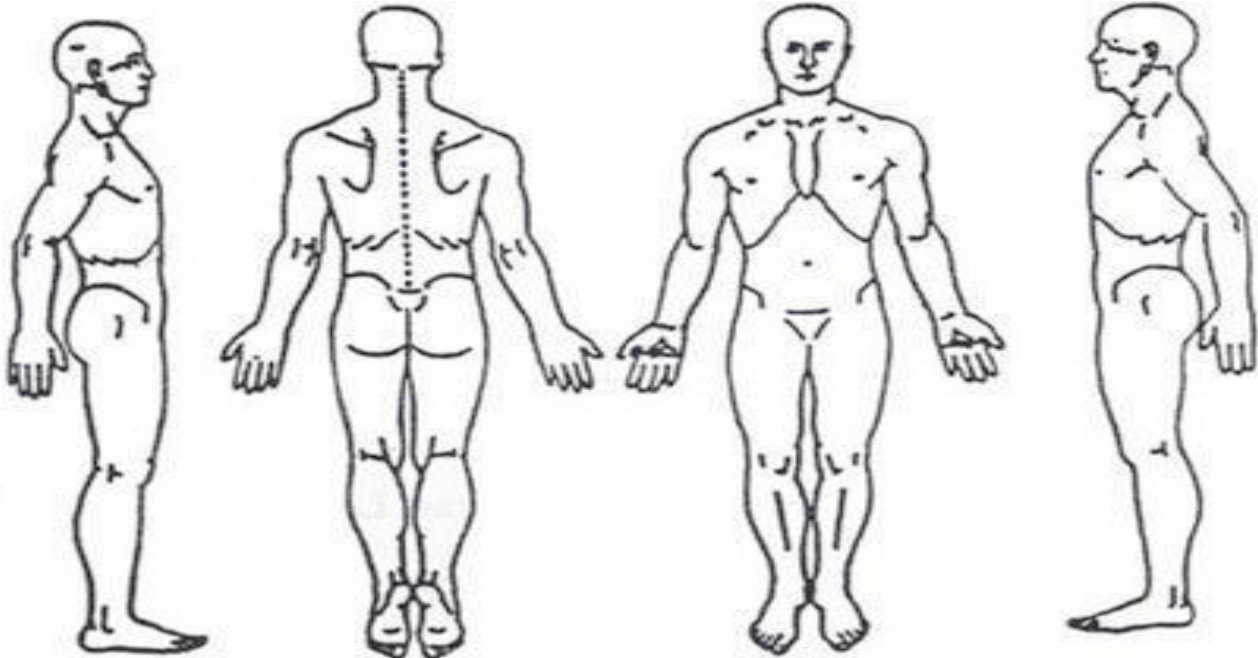
Please circle areas on the diagram below that you feel need extra work. Cross out any areas you would like to be avoided.



Preferred Pressure (circle one): Light Medium Deep ???

Signature: ____