personal information

name __________________________ date of birth __________________________

ame __________________________

city __________________________ state __________________________ zip ______

city __________________________ state __________________________ zip ______

home phone __________________________ cell phone __________________________

work phone __________________________ ext. __________________________

email __________________________

occupation __________________________

employer __________________________

employer address __________________________

marital status __________________________ if married, spouses name ______________

referred by __________________________

emergency contact name (relationship) __________________________ emergency contact phone __________________________

physician’s name __________________________ physician’s phone __________________________

massage experience

Have you had a professional massage before? ☐ Yes ☐ No

If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)? __________________________

How long have you been receiving massage therapy? __________________________

Frequency of massages? __________________________

What are your goals for treatment? __________________________

health history

Musculoskeletal

Bone or joint disease __________________________

Tendonitis/Bursitis __________________________

Arthritis/Gout __________________________

Jaw Pain (TMJ) __________________________

Lupus __________________________

Spinal Problems __________________________

Migraines/Headaches __________________________

Osteoporosis __________________________

Respiratory

Breathing Difficulty/Asthma __________________________

Emphysema __________________________

Allergies, specify: __________________________

Sinus Problems __________________________

Nervous System

Shingles __________________________

Numbness/Tingling __________________________

Pinched Nerve __________________________

Chronic Pain __________________________

Paralysis __________________________

Multiple Sclerosis __________________________

Parkinson’s Disease __________________________

Reproductive

Pregnant, stage __________________________

Ovarian/Menstrual Problems __________________________

Prostate __________________________

Skin

Allergies, specify: __________________________

Rashes __________________________

Cosmetic Surgery __________________________

Athlete’s Foot __________________________

Herpes/Cold Sores __________________________

Digestive

Irritable Bowel Syndrome __________________________

Bladder/Kidney Ailment __________________________

Colitis __________________________

Crohn’s Disease __________________________

Ulcers __________________________

Psychological

Anxiety/Stress Syndrome __________________________

Depression __________________________

Other

Cancer/Tumors __________________________

Diabetes __________________________

Drug/Alcohol/Tobacco Use __________________________

Contact Lenses __________________________

Dentures __________________________

Hearing Aids __________________________

Any other medical condition(s) not listed: __________________________

Please explain any of the conditions that you have marked above: __________________________

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This form was created as a resource by the American Massage Therapy Association® and they are not held liable for any services provided.
client agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. I understand that the american massage therapy association* has provided this form as a reference and is not held liable for any services provided.

signature  date

assignment of benefits

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance.

I authorize and direct payment of medical benefits to my massage therapist, for services billed.

signature  date

release of medical records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.

signature  date

contract for care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions’ plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

I authorize and direct payment of medical benefits to my massage therapist, for services billed.

signature  date

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