Massage intake form

Massage Therapy Intake & Informed Consent

Please complete this form before your massage session. Your answers help your massage therapist understand your goals, identify areas that may need to be avoided or adapted, and provide a safer, more comfortable session.

Important information

Massage therapy involves professional therapeutic touch, pressure, positioning, and movement of soft tissues. Massage therapists do not diagnose medical conditions, prescribe medication, or replace care from a physician or other qualified healthcare professional.

Depending on the information you provide, your therapist may modify the session, avoid certain techniques or areas, postpone treatment, or recommend medical clearance before proceeding.

Some people may experience temporary tenderness, soreness, fatigue, or light-headedness after massage. Results vary, and no specific outcome is guaranteed.

Consent, draping & professional boundaries

You are in control throughout the session. You may ask for changes to pressure, positioning, draping, techniques, or areas being treated, and you may stop the session at any time.

Your therapist will use appropriate draping and expose only the area being worked on. Massage is strictly professional and non-sexual. Areas requiring specific consent will only be treated with your permission and in accordance with applicable professional standards and local requirements.

Client information

Contact details *

First name *

Last name *

Phone *

Email *

Date of birth *

Emergency contact name

Emergency contact phone number

Occupation or typical daily activity

Massage goals & preferences

Have you received professional massage therapy before? *

- ◯ No, this is my first massage
- ◯ Yes, occasionally
- ◯ Yes, regularly

What would you like help with today? Select all that apply. *

- ☐ Relaxation or stress reduction
- ☐ Muscle tension or soreness
- ☐ Pain or discomfort support
- ☐ Sports or activity recovery
- ☐ Mobility or flexibility
- ☐ General wellness
- ☐ Other

Which areas would you like the therapist to focus on? Select all that apply.

- [ ] Neck
- [ ] Shoulders
- [ ] Upper back
- [ ] Lower back
- [ ] Hips
- [ ] Arms or hands
- [ ] Legs
- [ ] Feet
- [ ] Scalp or face
- [ ] Full body
- [ ] Other

Are there any areas you do not want massaged or would like the therapist to avoid?

Describe any current pain, tenderness, numbness, tingling, restricted movement, or recent injury that may affect your massage.

Health history

Select any health conditions or considerations that currently apply.

- [ ] High or low blood pressure
- [ ] Heart or cardiovascular condition
- [ ] History of blood clots or DVT
- [ ] Bleeding or clotting disorder
- [ ] Diabetes
- [ ] Neuropathy or reduced sensation
- [ ] Cancer or current cancer treatment
- [ ] Osteoporosis or bone fragility
- [ ] Arthritis or joint condition
- [ ] Varicose veins or circulation concerns
- [ ] Swelling, edema, or lymphatic condition
- [ ] Skin condition, rash, open wound, or infection
- [ ] Fever or contagious illness
- [ ] Chronic pain condition
- [ ] Headaches or migraines
- [ ] Neurological condition
- [ ] Recent surgery or hospitalization
- [ ] Recent sprain, strain, fracture, or other injury
- [ ] Other condition relevant to massage

Please provide details about any health conditions selected above, including anything your therapist should know.

List any current medications or supplements that may be relevant to massage, including blood-thinning medication.

List any allergies or sensitivities, including reactions to oils, lotions, fragrances, adhesives, or topical products.

Describe any surgery, hospitalization, medical procedure, or significant injury within the past 12 months.

Are you currently pregnant or could you be pregnant?

- ◯ No
- ◯ Yes
- ◯ Unsure
- ◯ Not applicable

If pregnant, please note how many weeks and any complications, restrictions, or guidance from your healthcare provider.

Do you have difficulty or discomfort lying in any of these positions? Select all that apply.

- [ ] Face down
- [ ] Face up
- [ ] On my left side
- [ ] On my right side

Anything else about your health, comfort, mobility, or recent changes that your therapist should know?

Session preferences & boundaries

What pressure do you generally prefer? *

- ◯ Light
- ◯ Medium
- ◯ Firm or deep
- ◯ No preference — please recommend

Gluteal muscle work preference *

- ◯ No gluteal work
- ◯ Over the drape only
- ◯ Direct external gluteal work with appropriate draping
- ◯ Discuss with me before deciding

Do you have any other preferences or boundaries you would like your therapist to know before the session?

Acknowledgment & signature

- ☐ I confirm that the information I provided is accurate to the best of my knowledge, and I will tell my therapist about relevant changes to my health, medications, injuries, or pregnancy status. *

- ☐ I understand that massage therapy does not diagnose or treat medical conditions and is not a substitute for medical care from a qualified healthcare professional. *

- ☐ I understand that I may request changes to pressure, positioning, draping, techniques, or areas being treated, and that I may stop the session at any time. *

- [ ] I understand that massage therapy is professional and non-sexual, and I consent only to the areas and techniques discussed with my therapist. *

- [ ] I voluntarily consent to receive massage therapy based on the information provided above. *

Client signature *