Burke Rehabilitation Hospital l Massage Therapy

Adult Fitness Center	Mamaroneck Outpatient	Somers Outpatient
785 Mamaroneck Ave.	703 West Boston Post Road	325 Route 100, Suite 106
White Plains NY 10605	Mamaroneck, NY 10543	Somers, NY 10589
P. 914-597-2805 l F. 914-597-2809	P. 914.597.2557 l F. 914.798.4130	P. 914.597.2890 l F. 914.669.5061

Client Intake Form l Massage Therapy

Personal Information:
Name______________________________ Phone (Day)_______________ Phone (Eve)______________
Address____City/State/Zip
Email__________________________________ Date of Birth__________ Occupation________________
Emergency Contact Phone____

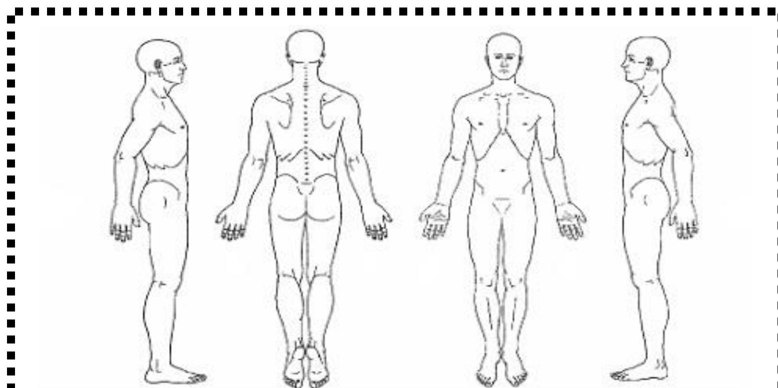
The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.
Date of Initial Visit________________________

1. Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy?_____________________________________
2. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain
____
____
3. Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain ____
4. Do you have sensitive skin? Yes No
5. Are you wearing contact lenses dentures hearing aid? (please circle)
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe ____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe____
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?

☐ muscle tension ☐anxiety ☐ insomnia ☐ irritability ☐other ________________________

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No
If yes, please identify____
10. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain
____
____

Please Circle any area that you would like the massage therapist to focus on during your session



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Medical History

In order to plan a massage session that is safe and effective, I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No
If yes, please explain____
12. Do you see a chiropractor? Yes No
If yes, how often?____
13. Are you currently taking any medication? Yes No
If yes, please list ____

14. Please check any condition listed below that applies to you:

( ) contagious skin condition
( ) open sores or wounds
( ) easy bruising
( ) recent accident or injury
( ) recent fracture
( ) recent surgery
( ) artificial joint
( ) sprains/strains
( ) current fever
( ) swollen glands
( ) allergies/sensitivity
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis
( ) phlebitis
( ) deep vein thrombosis/blood clots
( ) joint disorder/rheumatoid arthritis/ osteoarthritis/tendonitis
( ) osteoporosis
( ) epilepsy
( ) headaches/migraines
( ) cancer
( ) diabetes
( ) decreased sensation
( ) back/neck problems
( ) Fibromyalgia
( ) TMJ
( ) carpal tunnel syndrome
( ) tennis elbow
( ) pregnancy If yes, how many months?_____

Please explain any condition that you have marked above
____
____
____

15. Is there anything else in regards to your medical history that may be beneficial for your massage therapist to know to plan a safe and effective massage session for you?
____
____
____