UFHealth
UNIVERSITY OF FLORIDA HEALTH

Massage Therapy Intake Form

First Name: _____ Last Name: _____

Phone (Day): _____ Phone (Eve): _____

Address: _____ City/State/Zip: _____

Email: _____ Preferred Contact Method: _____

Date of Birth: _____/_____/_____ Occupation: _____

Emergency Contact and relationship: _____ 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: _____/_____/_____

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

If yes, how often do you receive massage therapy? _____

Do you have difficulty lying on your front, back, or side? ☐ Yes ☐ No

If yes, please explain: _____

Do you have allergies to oils, lotions, or ointments? ☐ Yes ☐ No

If yes, please explain: _____

Do you have sensitive skin? ☐ Yes ☐ No

Please check boxes if you wear any of the following:

☐ Contact lenses ☐ Dentures ☐ Hearing aid

Do you sit for long hours at a workstation, computer, or driving? ☐ Yes ☐ No

If yes, please describe: _____

Do you perform any repetitive movements in your work, sports, or hobby? ☐ Yes ☐ No

If yes, please describe: _____

Do you experience stress in your work, family, or other aspects of your life? ☐ Yes ☐ No

If yes, how do they affect your health?

☐ Muscle tension ☐ Anxiety ☐ Insomnia ☐ Irritability

☐ Other: _____

Please identify some personal goals for this massage session:

_____

Please identify particular areas of the body where you are experiencing tension, stiffness, pain, or other discomfort:

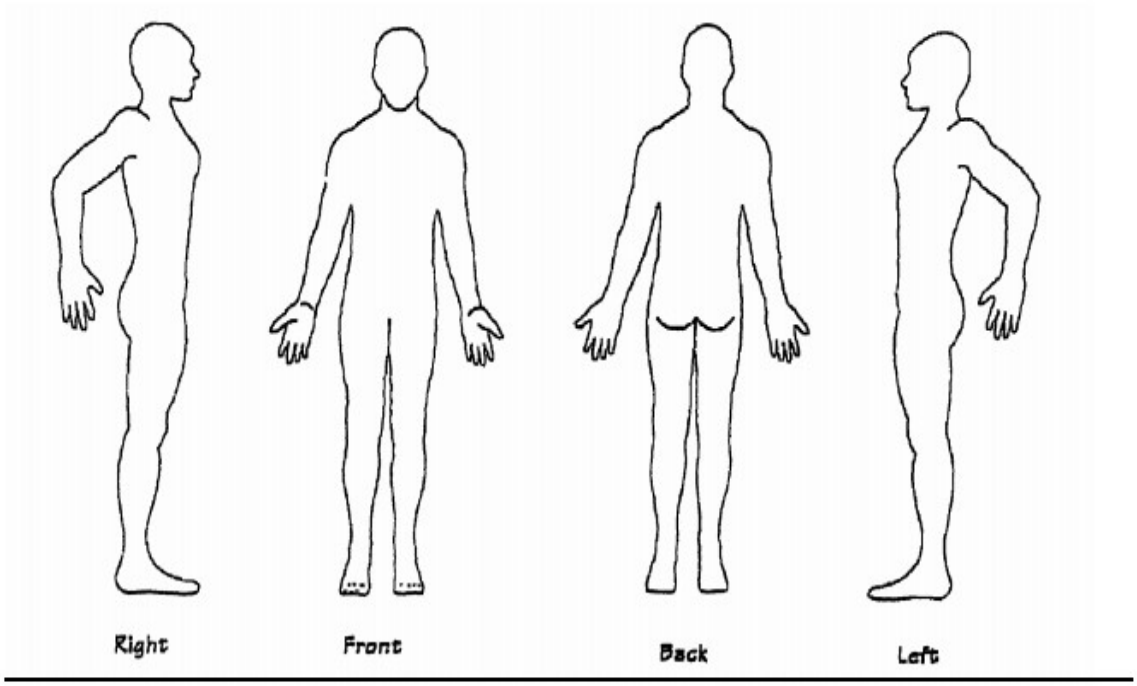
_____

_____

Identify any specific areas you would like the massage therapist to concentrate on during the session

Please use the letters provided in the key to identify the symptoms you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

P= pain or tenderness
S= joint or muscle stiffness
N= numbness or tingling



Draping will be used during the session – only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17. For more in-depth massage associated with certain medical diagnosis, i.e.: lymphatic drainage, undraping above the waist may be purposeful.

Please check if you consent ☐ or decline ☐ Please initial: _____

I, _____understand that the massage I receive is provided for the purpose of relaxation, relief of muscular tension, and spasm or pain. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Please initial: _____

I understand that I am receiving massage therapy at my own risk. In the event that I become injured either directly or indirectly as a result, in whole or in part, of the aforesaid massage therapy I hereby hold harmless and indemnify the therapist, their principals, and agents from all claims and liability whatsoever.

Please initial: _____

Sexual advances, request for sexual favors, and other verbal or physical conduct of a sexual nature will constitute as sexual harassment and will not be tolerated.

Please initial: _____

If I am unable to attend my scheduled appointment, I will provide notice, in a minimum of 2 business days prior for rescheduling or cancellation. For rescheduling or cancellation please call (352) 265-9355. Failure to provide notice of cancellation will result in a "no show". 3 "no shows" in a 12 month calendar year may result in discharge from our clinic.

In order to give everyone their scheduling time, if you are late for your appointment, it may be deducted from your allotted time:

Please initial: _____

If in any event my medications or medical history changes, I will notify the massage therapist prior to receiving massage therapy.

Please initial: _____

Signature of Client: _____ Date: _____

Thank you so much for taking the time to complete this form and we look forward to addressing your healing needs.

Any questions or additional concerns please discuss with your massage therapist prior to your massage session.

https://ufhealth.org/integrative-medicine