Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us?
_____

Medical Information

Are you taking any medications? □ yes □ no

If yes, please list name and use:
_____
_____

Are you currently pregnant? □ yes □ no

If yes, how far along?
_____

Any high risk factors?
_____

Do you suffer from chronic pain? □ yes □ no

If yes, please explain
_____

What makes it better?
_____
_____

What makes it worse?
_____
_____

Have you had any orthopedic injuries? □ yes □ no

If yes, please list:
_____

Please indicate any of the following that apply to you.

□ Cancer
□ Fibromyalgia
□ Headaches/Migraines
□ Arthritis
□ Diabetes
□ Joint Replacement(s)
□ High/Low Blood Pressure
□ Neuropathy
□ Stroke
□ Heart Attack
□ Kidney Dysfunction
□ Blood Clots
□ Numbness
□ Sprains or Strains

Explain any conditions you have marked above:

_____
_____
_____
_____

Massage Information

Have you had a professional massage before? □ yes □ no

What type of massage are you seeking?

□ Relaxation □ Therapeutic/Deep Tissue

Other

_____

What pressure do you prefer?

□ Light □ Medium □ Deep

Do you have any allergies or sensitivities? □ yes □ no

Please explain

_____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? □ yes □ no

Please explain

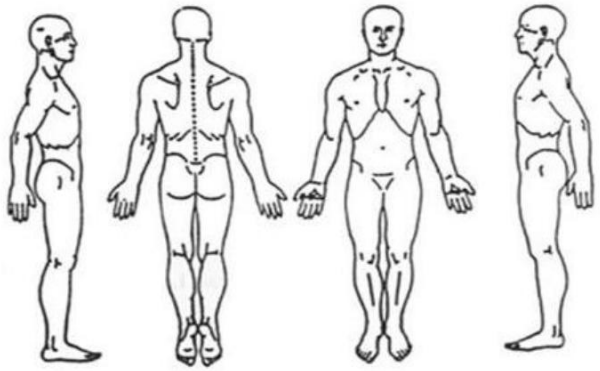
_____

What are your goals for this treatment session?

_____

_

Please circle any areas of discomfort



By signing below you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____