

Barefoot Therapy Massage Intake Form

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Personal Information

Name: _____ Phone:(day) _____ (evening) _____

Address: _____ City/State/Zip: _____ DOB: _____

Occupation: _____ Employer: _____

Email: _____ Primary Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

- Veteran/Active Service LEO/Dispatch First Responder Emergency Department Employee Teacher
 Minor Dependent of any of these listed

How did you hear about Barefoot Therapy?: _____

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.

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Sprains or Strains |
| <input type="checkbox"/> Received Covid Vaccine (for side effect information only) | |
| Date Received: _____ | |

Explain any conditions you have marked above or any additional conditions that you have: _____

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 Firm [Deep (add 50¢/min)]

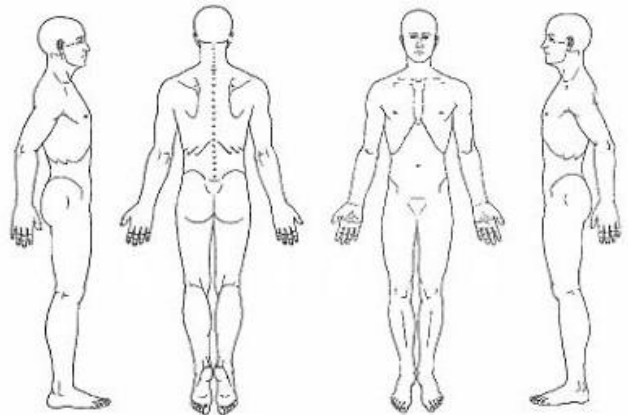
Do you have any allergies or sensitivities? Yes No

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 (or Legal Guardian) Signature _____ Date _____

Therapist Signature _____ Date _____