Therapeutic Massage- Client Intake Form

Name ____________________________ Phone____________________________

Address:____________________________ City, State, Zip ______________________________

Email__________________________ Date of Birth__________________

Occupation______________________ Referred By___________________

Have you ever received a professional massage before?_______

If yes, how often?_________________

What kind of pressure do you prefer? (circle one)

Light Medium Deep

What kind of massage are you seeking today?

Relaxation Deep Tissue/ Therapeutic

Prenatal Hot Stone

Are there any areas where massage should be avoided? (i.e. scalp, face, glutes, pecs, feet)

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What are your common areas of pain or tension?

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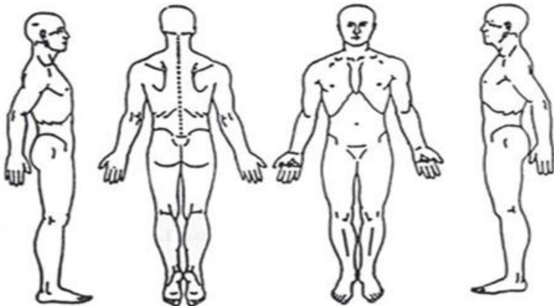
Circle any specific areas you would like focused on



Medical History

Do you suffer from any chronic or persistent pain or discomfort? _________________________

If so, for how long? ______________________

Do you know what causes symptoms to get worse or better? ______________________________

Are you currently under any medical care?

____

Are you taking any prescription medication? If so, for what?___________________________

____

Indicate any conditions you have had, or currently have:

Headaches/ Migraines _______
Allergies/Sensitivity _______
Arthritis/Tendonitis _______
Cancer/Tumors _______
Heart/Circulation Problems _______
High/Low Blood Pressure _______
Varicose Veins _______
Blood Clots _______
Diabetes _______
Neck/Back Injuries _______
Fibromyalgia _______
Numbness _______
Sprains/Strains _______
Previous Surgeries _______
Recent Injuries _______
Lack of, or Reduced Feeling/Sensation _______

Explain any conditions you have marked above

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Patient Signature ____ **Date** ________________