Massage Intake Form

Personal Information

1. Date of Birth:

2. Occupation:

Type your answer here

3. Primary Physician:

Type your answer here

4. Emergency Contact: *

Type your answer here

5. Emergency Contact Relationship: *

Type your answer here

6. Emergency Contact Phone: *

Type your answer here

7. How did you hear about us?

Type your answer here

Medical Information

8. Are you taking any medications? *

- Yes
- No

9. If yes, please list name and use:

Type your answer here

10. Are you currently pregnant? *

- Yes
- No

11. If yes, how far along:

Type your answer here

12. Issues you wish to address during treatment

Type your answer here

13. Do you suffer from chronic pain? *

- Yes
- No

14. If yes, please explain:

Type your answer here

15. What makes it better?

Type your answer here

16. What makes it worse?

Type your answer here

17. Have you had any orthopedic injuries? *

- ( ) Yes
- ( ) No

18. If yes, please list:

Type your answer here

19. Please indicate any of the following that apply to you: *

- [ ] Cancer
- [ ] Headaches/Migranes
- [ ] Arthritis
- [ ] Diabetes
- [ ] Joint Replacement
- [ ] High/Low Blood Pressure
- [ ] Neurotherapy
- [ ] Fibromyalgia
- [ ] Stroke

- [ ] Heart Attack
- [ ] Kidney Dysfunction
- [ ] Blood Clots
- [ ] Numbness
- [ ] Sprains or Strains
- [ ] Parkinsons
- [ ] Asthma
- [ ] Chronic Cough
- [ ] Shortness of breath
- [ ] Skin Conditions
- [ ] Lymphedema
- [ ] Bruise Easily
- [ ] Jaw Pain TMJD
- [ ] Gout
- [ ] Insomnia
- [ ] Epilepsy
- [ ] Shingles
- [ ] Artificial Joints / Special Equipment
- [ ] Digestive Conditions
- [ ] Lupus
- [ ] None of the Above

20. Explain any conditions you have marked above:

Type your answer here

21. Are there any other conditions that not listed above?

Type your answer here

22. Have you had a professional massage before?

- Yes
- No

23. What pressure do you prefer? *

- Light
- Medium
- Deep

24. Do you have any allergies or sensitivities? *

- Yes
- No
- Not Sure

25. If yes, please explain:

Type your answer here

26. What are you goals for this treatment session?

Type your answer here

By signing below, I agree that all the information above is true. *

I agree to use electronic records and signatures.

Clear

Submit