MASSAGE THERAPY INTAKE FORM

NAME ____ DATE OF BIRTH ________________

STREET ADDRESS ____

CITY, STATE, ZIP ____

PHONE NUMBER ____________________ EMAIL ADDRESS _________________________________

OCCUPATION ____

EMERGENCY CONTACT NAME ____

RELATIONSHIP ______________________________ PHONE NUMBER ___________________________

What is the best way to contact you for appointment reminders? ______________________________

Primary reason(s) for seeking massage therapy: ____

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Please list any medications or supplements you are taking: _________________________________

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Please check any conditions that apply, with explanation if necessary

headaches, migraines
chronic pain
allergies, sinus congestion
head injury
digestive issues
blood clots
surgeries
sprains, fractures
joint pain, arthritis
numbness or tingling
cancer, other growths

diabetes
depression, anxiety
stress
heart or circulatory problems
varicose veins
other medical conditions
sensitive skin
tendonitis
major viral infection
(mononucleosis, covid-19, severe flu)

I agree that I am personally responsible for prompt payment of all services. A 24 hour cancellation notice is requested, otherwise a $15 cancellation fee will be billed. I understand that massage therapy is not a substitute for medical examination or diagnosis and that I should see a medical doctor for these services. Unwelcome sexual behavior or requests constitutes sexual harassment and will not be tolerated.

Signature ____ Date ________________________