***Massage Intake Form***

**Name:** **Age:** **Today’s Date:**

**Address:**

**Are you pregnant?** **Any details Your Therapist should know:**

Yes / No

**Are you currently on any medication?**

**Have you had any surgeries?**

**Do you have any Allergies?**

**Do you have any of the following?**

* Asthma
* Arthritis
* Eczema
* Diabetes
* Cancer
* Chronic Neck/Back Pain
* PMS
* Carpal Tunnel
* Varicose Veins
* Heart Disease
* Anemia
* High/Low Blood Pressure
* Digestive Disorders
* Infectious Disease
* Migraines
* Epilepsy
* Edema
* Ulcer

**Do you have any chronic pain:**

**Your session:**

**What kind of music would you prefer? Circle Prefered.**

Jazz Ambient/No Piano Soft Instruments Storms/Nature

Below are listed the sensitive areas of the body. Check the box(es) that you give consent to having massaged. Your therapist can point out these areas on their body if you are unfamiliar. Any area left unchecked **will not** bemassaged under any circumstances, until you have filled out a new area of consent form (we can provide this at any time).

* Scalp
* Pectoral Muscles
* Abdomen
* Gluteal Muscles
* Hip Flexors
* Feet

If you should fall asleep during the session, by signing below, you are acknowledging that your therapist will gently wake me at the end of the session with a light tap on the shoulder and saying my name. (Write below if you have a different preference)

Signature: Date: