

# Massage Intake Form

## Personal Information

Name \_\_\_\_\_ Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ DOB \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Email \_\_\_\_\_ Primary Physician \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## 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.

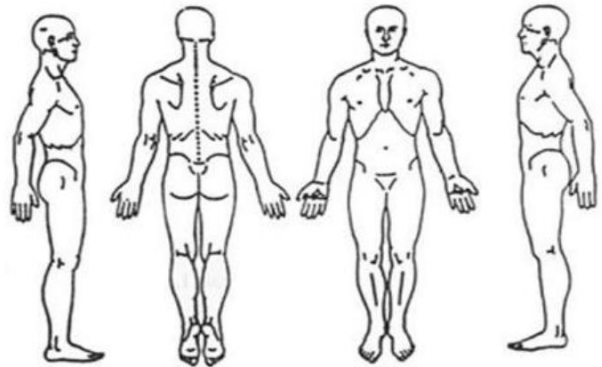
- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart 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 |

Explain any conditions you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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 ☐ Deep  
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 Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_