Date ____/____/_____

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 condition you have had in the past or currently have.

☐Cancer ☐Fibromyalgia
☐Headaches/Migraines ☐Stroke
☐Arthritis ☐Heart Attack
☐Diabetes ☐Kidney Dysfunction
☐Joint Replacement(s) ☐Blood Clots
☐High/Low Blood Pressure ☐Numbness
☐Neuropathy ☐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

Are you sensitive to any fragrances? ☐yes ☐no

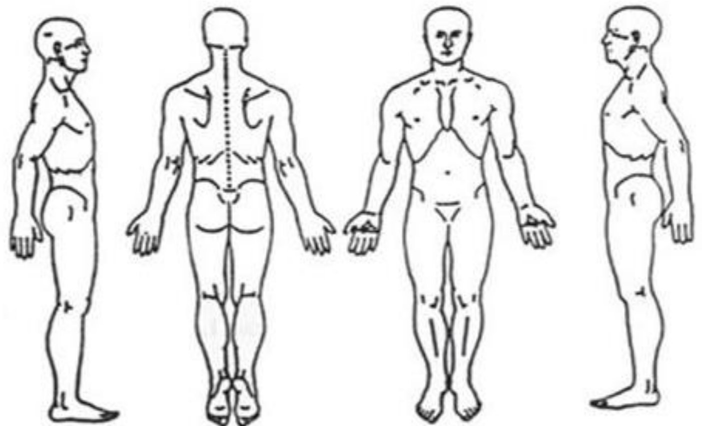
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐yes ☐no

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* ________