Elysium Massage
Intake form

Name _____ Email _____
Phone(cell/day) _____ DOB _____ Age _____
Address _____ City/State/Zip _____
Emergency Contact Name _____ Phone _____ Relationship _____
Occupation _____ Referred By_____

Are you taking any medications? □yes □no If yes please list _____
_____
_____

Are there any side effects your therapist should be aware of ? (dizziness, fatigue, low blood pressure, ect)?
□yes □no If yes please list _____
_____

Do you have any allergies or hypersensitivities? □yes □no If yes please list _____
_____
_____

Are you currently under medical supervision or receiving other medical interventions? □yes □no
If yes please describe _____
_____

Please list any medical or health conditions (cancer, multiple sclerosis,vertigo, seizures ect) : _____
_____
_____

any injuries and medical procedures in the last two years? □yes □no If yes please list _____
_____
_____

Do you have any implants or recent injection sites (insulin pump, pacemaker, ect)? □yes □no What /where?
_____
_____

Do you have any infectious or contagious conditions (TB, fungal infections, shingles, warts, ect) ? □yes □no
If yes please list _____
_____

Client signature _____ Date_____

Therapist signature _____ Date_____