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.

- □ Cancer
- □ Headaches/Migraines
- □ Arthritis
- □ Diabetes
- □ Joint Replacement
- □ High/Low Blood Pressure
- □ Neuropathy
- □ Fibromyalgia
- □ Stroke
- □ Heart Attack
- □ Kidney Dysfunction
- □ Blood Clots
- □ Numbness
- □ Sprains or Strains

Explain any conditions you have marked above or not listed 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 _____

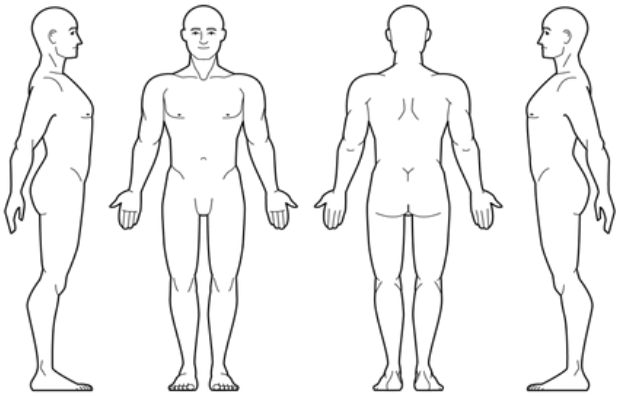
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? □ yes □ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below, I acknowledge that I am aware of the benefits and risk of massage therapy and that 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 an y t i me.

Client Signature _____ *Date* _____

Therapist Signature _____ *Date* _____

Massage Consent

Please take a moment to carefully read and sing where indicated.
If you have a medical condition or specific symptoms, Massage therapy may be problematic to you.It is possible that a referral from you heath care provider may be prior to treatment.

- I understand that the treatment I receive is for basic purpose of relaxation and relief of muscular tension.

  Initials: _____

- If at any point during the massage I am uncomfortable with the procedure being administered and/or I experience pain it is my responsibility to IMMEDIATELY inform the massage therapist so the massage can be terminated or pressure or strokes can be adjusted to a level of comfort.

- I understand that massage therapy is not suite able for a medical examination,diagnosis or treatment
- Prior to massage please remove all jewelry pull long hair back

- Please provide feedback as to pressure (lighter/Deeper) discuss painful or ticklish areas of your body

- Any illicit or sexual suggestive remarks or advances will result in immediate termination of treatment

- Feel free to ask questions about the procedures. The massage therapy provider is well trained, ethical and professional and will be happy to help you be well informed and comfortable.

Client Signature: Date: