# 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? _____

## Health 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? ☐ yes ☐ no

Please explain: _____

_____

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 explain: _____

_____

Please indicate any of the following that apply to you.

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

Explain any conditions you have marked above:

_____

_____

_____

_____

## Massage Information

Have you ever had a professional massage? ☐ yes ☐ no

When? _____

What type of massage are you seeking?

☐ Relaxation ☐ Theraputic/Deep Tissue

Other _____

_____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

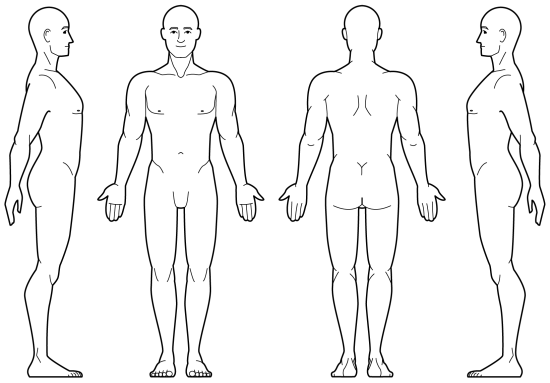
Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

_____

_____

Please circle any areas of discomfort:



What are your goals for this treatment session?

_____

_____

_____

*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 Massage Therapist if any of the above information changes at any time.*

*Client Signature* _____ *Date* _____

*Therapist Signature* _____ *Date* _____