Massage Client Intake Form

Please complete this form before your session to help ensure your safety and comfort.

Full Name *

First Name Last Name

Date of Birth *

Month Day Year

Phone Number *

Please enter a valid phone number.

Email Address *

example@example.com

Address *

Street Address

Street Address Line 2

City State / Province Postal / Zip Code

Emergency Contact Name *

First Name Last Name

Emergency Contact Relationship *

Emergency Contact Phone Number *

Please enter a valid phone number.

Have you had any surgeries? *

- ○ No
- ○ Yes

If yes, please list type and date of surgeries

Have you experienced any injuries? *

- ○ No
- ○ Yes

If yes, please describe your injuries

Do you have any chronic medical conditions? *

- ☐ None
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Other

Please list any medications you are currently taking

Do you have any allergies? *

- ○ No
- ○ Yes

If yes, please list your allergies

Are you currently experiencing any of the following?

- ☐ Fever
- ☐ Cold or Flu Symptoms
- ☐ Contagious Skin Condition
- ☐ Infectious Disease
- ☐ Recent Injury
- ☐ Other

Are you currently pregnant? *

- ○ No
- ○ Yes
- ○ Not Applicable

Please indicate any areas of pain or tension

Massage Pressure Preference *

Ligh
t

- ○ Medium
- ○ Firm

Are there any areas you would like to avoid during the massage?

Preferred areas to focus on

Do you have any other preferences or concerns regarding your massage session?

Informed Consent & Liability Waiver

Date *

Month Day Year

Massage Therapy & Professional Boundaries Disclaimer *