

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.

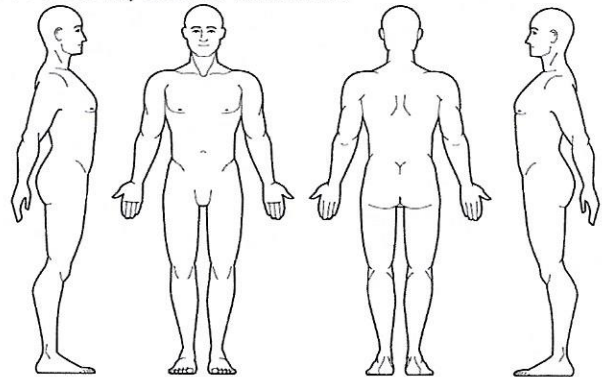
- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> 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
 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, 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 _____

Therapist Signature _____ Date _____