

# Massage Intake Form

## Personal Information

Name \_\_\_\_\_ Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ DOB \_\_\_\_\_

Occupation \_\_\_\_\_ ~~\*\*\*\*\*~~

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 ~~\*\*\*\*\*~~

Other \_\_\_\_\_

What pressure do you prefer?

Light  Medium ~~\*\*\*\*\*~~

Do you have any allergies or sensitivities?  yes  no

Please explain \_\_\_\_\_

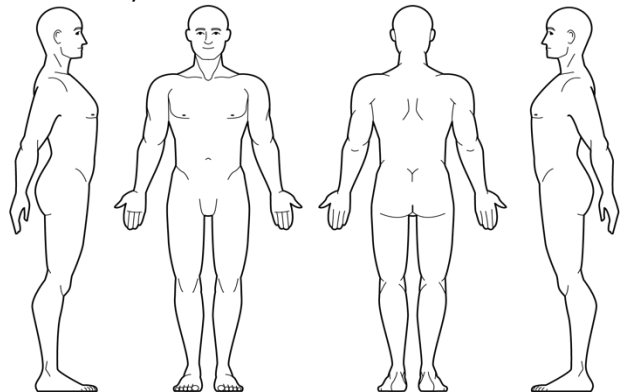
Are there any areas (feet, face, abdomen, etc.) you do not want massaged?  yes  no

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 \_\_\_\_\_