Date ____/____/_____

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 condition you have had in the past or currently have.

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

Are you sensitive to any fragrances? ☐yes ☐no

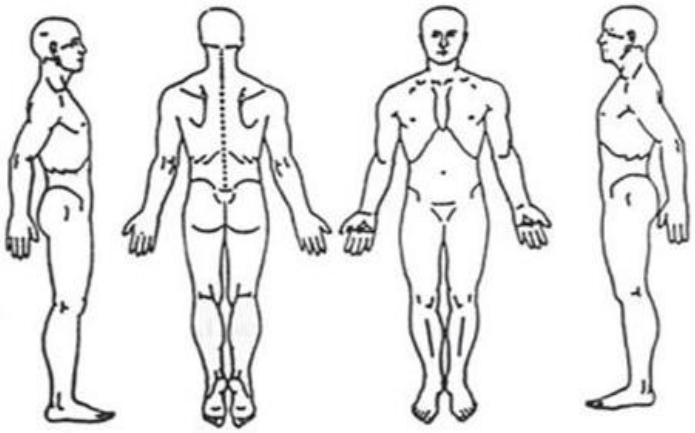
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐yes ☐no

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* _____