Massage Intake Form

Name _____ Phone (day) _____

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?

_____

Any orthopedic injuries? ☐yes ☐no
If yes, please list:

_____

Please indicate any of the following that apply:
☐ Cancer ☐ Headaches/Migraines ☐ Arthritis
☐ Diabetes ☐ Joint Replacement(s)
☐ High/Low Blood Pressure ☐ Neuropathy
☐ Fibromyalgia ☐ Stroke ☐ Heart Attack
☐ Kidney Dysfunction ☐ Blood Clots
☐ Numbness ☐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

_____

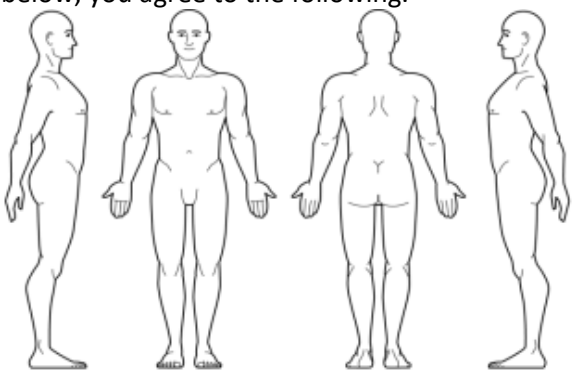
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no
Please explain

_____

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 _____