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 medication? ☐ Yes ☐ No
If yes, please list name and use: _____
_____

Are you currently pregnant? ☐ Yes ☐ No
If yes, how far along? _____
Any high risk factors? ☐ Yes ☐ No

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:

☐ 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

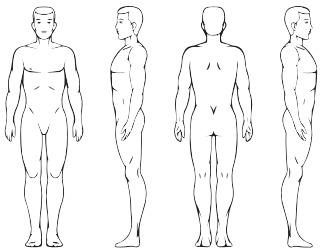
Please explain: _____

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:



I understand that my therapist does not diagnose illness, disease, or other physical or mental disorders. The massage therapist does not prescribe medical treatments or pharmaceuticals and it has been made clear to me that the massage is not a substitution for a medical examination or diagnosis, and that it is recommended that I see a physician for any physical ailment that I might have. I have stated all my medical conditions.

*Client Signature*_____
Date _____
Therapist Signature _____
Date _____

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