

Massage Intake Form

Personal Information

Name _____ Phone _____
Address _____ City/State/Zip _____
DOB _____ Occupation _____
Email _____ Physician _____
Emergency Contact _____ 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 risks factors? _____
Do you suffer from chronic pain? yes no
If yes, explain _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? yes no
If yes, 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 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? yes no
If yes please explain _____

Are there any areas you do not want massaged? _____

What are your goals for this treatment session? _____

Please list any areas of discomfort on your body: _____

***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 information changes at any time.***

Signature

Date