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 of the following that apply to you.

☐ 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
Do you have any allergies or sensitivities?		☐ yes ☐ no

Please explain:____

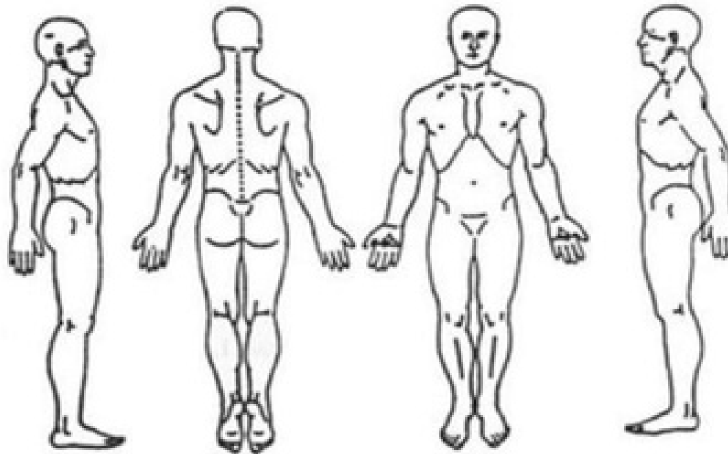
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

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* __________