Massage Intake Form

# Personal Information

Name

Address

Phone (day) (evening)

City/State/Zip DOB

Occupation Employer

Email Primary Physician

Emergency Contact Relationship Phone

How did you hear about us?

# Medical Information Massage 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.

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

* 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

*By signing below, you agree to the following.*

Explain any conditions you have marked above:

 \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

 \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

 \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

 \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

*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 \_\_\_\_\_\_\_\_\_\_*