



Massage Intake Form

Date ___/___/___

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 condition you have had in the past or currently have.

- 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

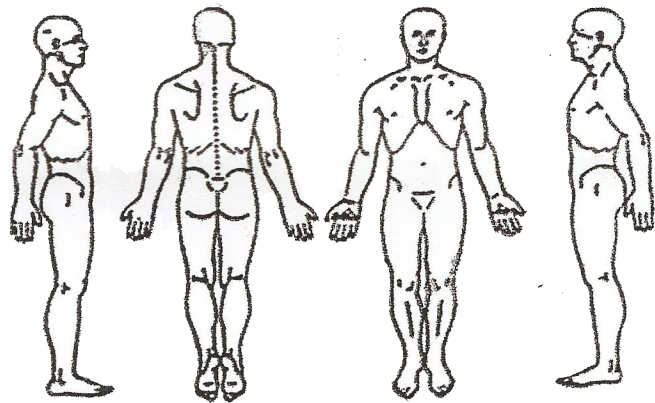
Are you sensitive to any fragrances? yes no

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 _____