

## 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.

- |                                                  |                                             |
|--------------------------------------------------|---------------------------------------------|
| <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 |

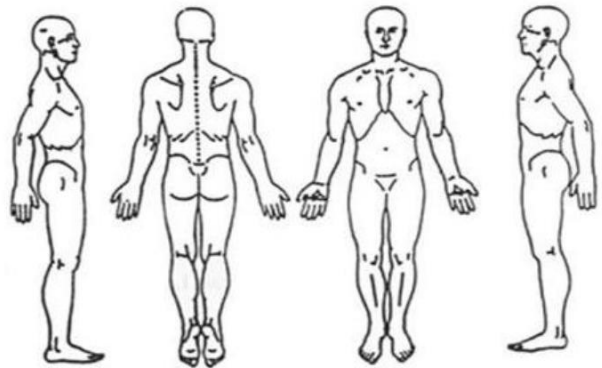
Explain any conditions you have marked above:

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

### Massage Information

Have you had a 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 \_\_\_\_\_