Massage Intake Form

Personal Information

Name: ______________________ Phone(home): ______________(cell): ______________

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: ______________________

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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:

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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?

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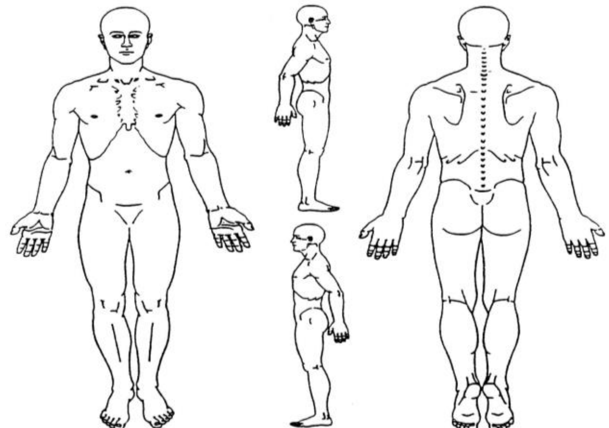
Please circle any areas of discomfort:



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:* __________