Massage Intake Form

Personal Information

Name	Phone	e (day)	(evening)	
Address	City/Sta	ate/Zip		DOB
Occupation		Employer		<u>-</u>
Email		Primary Physician		
Emergency Contact		Relationship	Phone	
How did you hear about us?				
Medical Information		Massage Information		
Are you taking any medications?	yes 🗆 no	Have you had a profession	nal massage before	e? 🗆 yes 🗀 no
If yes, please list name and use:		What type of massage are you seeking?		
***************************************		☐ Relaxation	☐ Therapeutic/D	Deep Tissue
Are you currently pregnant?] yes □ no	Other		
If yes, how far along?		What pressure do you prefer?		
Any high risk factors?		☐ Light	☐ Medium	□ Deep
Do you suffer from chronic pain?] yes 🗆 no	Do you have any allergies	or sensitivities?	□ yes □ no
If yes, please explain		Please explain		
What makes it better?		Are there any areas (feet, want massaged? Please explain	□ yes □ no	
What makes it worse?		What are your goals for the		
Have you had any orthopedic injuries?		Please circle any areas of	discomfort	
If yes, please list: Please indicate any of the following that ap				
□ 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:		By signing below, you agre I have completed this form		
		and agree to inform my the changes at any time.		
		Client Signature		Date
		Therapist Signature		Date