## **Massage Intake Form**

## Personal Information Name \_\_\_\_\_\_ Phone (day) \_\_\_\_\_ (evening) Address \_\_\_\_\_\_ City/State/Zip \_\_\_\_\_ \_\_\_\_\_DOB \_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Primary Physician \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone \_\_\_\_ How did you hear about us? **Medical Information** Massage Information Are you taking any medications? □ yes □ no Have you had a professional massage before? ☐ yes ☐ no If yes, please list name and use: What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/Deep Tissue Are you currently pregnant? ☐ yes ☐ no 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, face, abdomen, etc.) you do not want massaged? □ yes □ no Please explain \_ What makes it worse? \_\_\_\_\_ What are your goals for this treatment session? Have you had any orthopedic injuries? ☐ yes ☐ no Please circle any areas of discomfort If yes, please list: \_\_\_\_\_ Please indicate any of the following that apply to you. ☐ Cancer ☐ Fibromyaigla ☐ Headaches/Migraines ☐ Stroke Arthritis ☐ Heart Attack ☐ Diabetes ☐ Kidney Dysfunction ☐ Joint Replacement(s) ☐ Blood Clots ☐ High/Low Blood Pressure ☐ Numbness ☐ Neuropathy ☐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 \_\_\_\_\_