



Massage Intake Form

Name _____ Birth Date _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Do you currently have any injuries, disorders, diseases, or conditions? YES NO

Explain _____

Do you currently have any Pain or discomfort? YES NO

Are you taking any Medications? YES NO

Please List Type/ Reason/ Last Dose

Goals for Treatment: _____

If you have consumed any alcohol in the past 24 hours, what was the quantity and how long has it been?

ONE A FEW SEVERAL _____ HOURS

Have you ever had a professional massage? YES NO

If yes, how long has it been since your last one? _____

How Frequent? WEEKLY BI-WEEKLY MONTHLY ANUALLY RARELY/NEVER

I consent to having massage performed on me today. The information I have provided is accurate and I have not withheld any information in regards to my health for my own safety.

Signature _____ Date _____

Mark Areas of Pain with

