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.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ 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 _____

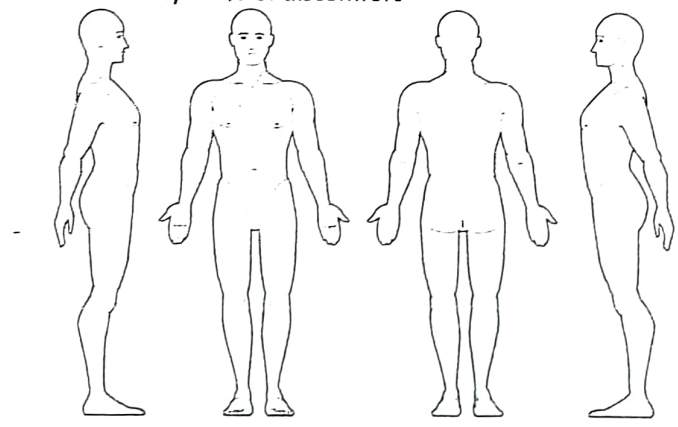
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

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*

Because a massage therapist must be aware of any existing physical conditions that I may have, I have listed all my known medical conditions and physical limitations and I will inform my massage therapist of any changes in my physical health.

I understand and agree that: (1) the massage therapy that I am given is for the purpose of stress reduction, relief from muscular tension or spasm and/or improving circulation, (2) that a massage therapist neither diagnoses illness, disease or any other medical, physical or mental disorder, nor performs any spinal manipulations, and (3) I am responsible for consulting a qualified physician for any physical ailments that I may have.

I agree that all services rendered to me are charged directly to me and I am responsible for payment at time of service unless pre-arrangements have been made. I agree to pay for 50% of any scheduled appointments that I am unable to keep unless I notify my therapist **AT LEAST 24 HOURS** in advance.

I also understand that any illicit or sexually suggestive remarks or advances made towards the massage therapist will result in immediate termination of the session and I will be liable for payment of said session.

_____ _____

Client Signature **Date**

_____

Printed Name