Massage Intake Form

Patient Information

Name_____Phone_____

Address_____City/State/Zip_____DOB_____

Occupation_____Employer_____

E-mail_____ Primary Physician_____

Emergency Contact_____Relationship_____Phone_____

Medical Information

Are you taking any medications?
If yes, please list them: _____

Are you currently pregnant?
If yes, how far along? _____
Any risk factors? _____

Do you suffer from chronic pain?
If yes, please explain_____

Have you had any injuries?
If yes, please list them:
_____

Mark any of the following apply to you:
- ☐ Cancer
- ☐ Headaches
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Numbness

Explain any conditions you have marked above:
_____

Massage Information

Have you had a professional massage?

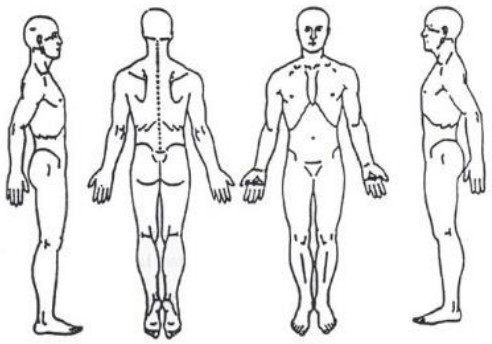
What type of massage are you seeking?
☐ Relaxation ☐ Therapeutic/Deep Tissue

What pressure do you prefer?
☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities?
Please explain _____

What are your goals for this session?
_____

Please circle any areas of discomfort



By signing below, I have completed this form to the best of my ability and knowledge and I understand that this massage is not a replacement for medical care.

Client Signature _____Date_____

Therapist Signature _____Date_____

We appreciate your business. If you scheduled a massage, please note that cancellations notices must be given at least 24 hours in advance. A $25 late cancellation fee will apply.

Patient/Responsible Party Initial _____