Massage Intake Form

Personal Information

Name _____ Phone: _____ DOB _____

Address _____ City/State/Zip _____

Email _____ Occupation _____

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Emergency Contact: _____ Relationship/Phone#_____

Name of Ins. Co: _____ ID/Policy#: _____ Policyholder: _____

Policyholder (if other than patient): Relationship: _____ DOB:_____ Phone#:_____

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

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

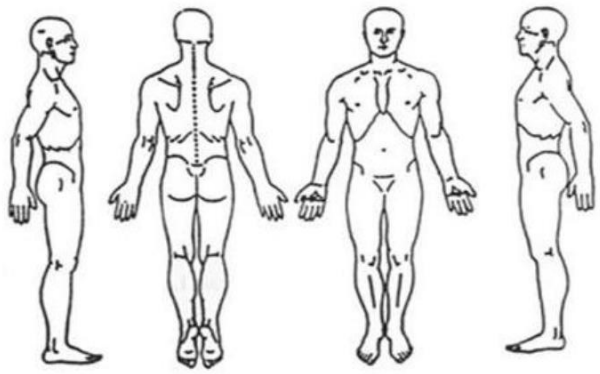
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

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* _____