Massage Intake Form

# Personal Information

Name

Address

Phone (day) (evening)

City/State/Zip DOB

Occupation Employer

Email Primary Physician

Emergency Contact Relationship Phone

How did you hear about us?

# Medical Information Massage 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.

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

* 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:

 \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

 \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

 \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

 \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists’ part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

*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 \_\_\_\_\_\_\_\_\_\_*