## 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	Massage Infor	mation
Are you taking any medications?		orofessional massage before?   yes   no   ussage are you seeking?  xation   Therapeutic/Deep Tissue
Are you currently pregnant?		merapeutic/ Deep Tissue
If yes, how far along?	What pressure d	o you prefer?
Any high risk factors?	Light	$\square$ Medium $\square$ Deep
Do you suffer from chronic pain? $\qed$ yes	☐ no ☐ Do you have any	allergies or sensitivities? $\square$ yes $\square$ no
If yes, please explain	Please exp	lain
What makes it better? What makes it worse?	want massaged? Please exp	eas (feet, face, abdomen, etc.) you do not yes no lain oals for this treatment session?
Have you had any orthopedic injuries?	Please circle any	areas of discomfort
□ Cancer       □ Fibromyalgia         □ Headaches/Migraines       □ Stroke         □ Arthritis       □ Heart Attack         □ Diabetes       □ Kidney Dysfu         □ Joint Replacement(s)       □ Blood Clots         □ High/Low Blood Pressure       □ Numbness         □ Neuropathy       □ Sprains or Strains	nction	
Explain any conditions you have marked above	e: I have completed	you agree to the following. this form to the best of my ability and knowledge rm my therapist if any of the above information me.
	 Client Signature _	Date
	Therapist Signatu	re Date