Maricopa City Mobile Massage

**MASSAGE INTAKE FORM**

**Personal Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone(day)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (evening)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information** **| Massage Information**

 **|**

Are you taking any medications? ☐yes ☐no **|** Have you had a professional massage before? ☐yes ☐no

If yes, please list name and use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **|** What type of massage are you seeking?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **|** ☐Relaxation/Swedish ☐Therapeutic/Deep Tissue

Are you currently pregnant? ☐yes ☐no **|** ☐Other:

If yes, how far along? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **|** What pressure do you prefer?

Any high risk factors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **|** ☐Light ☐Medium ☐Deep

Do you suffer from chronic pain? ☐yes ☐no **|** Do you have any allergies or sensitivities? ☐yes ☐no

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **|** Please explain:

What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **|** Are there any areas you do NOT want massaged (face etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **|** Please specify:

What makes it worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **|** What are your goals for this treatment session?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **|**

Have you had any orthopedic injuries? ☐yes ☐no **|** Please circle any areas of discomfort:

If yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **| **

Please indicate any of the following that apply to you: **|** What is your music preference?

 **|** ☐Relaxing ☐Nature ☐Soaking ☐other:

☐Cancer ☐Headaches/Migraines **|** Would you like to use CBD lotion for your session?

☐Arthritis ☐Diabetes **|** ☐ YES ☐ NO

☐Joint Replacement(s) ☐High/Low Blood Pressure **|** Preferred contact type? ☐Email ☐Phone ☐Text

☐Neuropathy ☐Fibromyalgia **|**

☐Stroke ☐Heart Attack *By signing below you agree to the following:*

☐Kidney Dysfunction ☐Blood Clots *I have completed this form to the best of my ability and knowledge*

☐Numbness ☐Sprains or Strains *and agree to inform my therapist if any of the above information*

 c*hanges at any time.*

Explain any conditions you have marked above. CLIENT SIGNATURE: DATE:

 THERAPISTS SIGNATURE: DATE:

 **FLIP TO COMPLETE OTHER SIDE >**