Massage Intake Form
CONFIDENTIAL INFORMATION

Welcome. I would like to make your experience and treatment as pleasant as possible.
If you have questions or concerns at any time, please let me know.

Name: ____ **Date of Birth:** ________________
Street: ____ **City:** ________________________
State: ________ **Zip Code:** _______________ **Occupation:**________________________________
Main Phone #:___________________________ **Alternate Phone #:**_________________________
Email Address: ____

Have you ever received massage therapy before? Yes No
If yes, what type of massage (e.g. Swedish, Deep Tissue, Energy, etc.)?___________________________

Are you currently pregnant? Yes No If yes, what trimester? 1st 2nd 3rd
Are you currently taking any medications? Yes No
If yes, please list name/type and reason for medications: __________________________________
____
____

Are you currently seeing a healthcare professional regularly? Yes No
If yes, please list name(s) and reason/treatment:____
____
____

Please review the below list and **X** the conditions that you have experienced in the past and now:

___ Anxiety
___ Arthritis
___ Asthma
___ Back Pain
___ Blood Clots
___ Broken Bone
___ Bruise Easily
___ Bursitis
___ Cancer
___ Carpal Tunnel Syndrome
___ Chronic Fatigue Syndrome
___ Chronic Bronchitis
___ Circulatory Issues
___ Constipation/Diarrhea
___ COPD
___ Degenerative Disc(s)
___ Depression
___ Diabetes
___ Dislocated Joint(s)
___ Diverticulitis
___ Eczema
___ Fibromyalgia
___ Headaches
___ Heart Condition(s)
___ Hepatitis (A, B, C or Other)
___ Herniated Disc(s)
___ High Blood Pressure
___ Lupus
___ Migraine
___ Multiple Sclerosis
___ Numbness
___ Peripheral Nerve Damage
___ Plantar Fasciitis
___ Psoriasis
___ Scoliosis
___ Seizures
___ Strains/Sprains
___ Surgery
___ TMJ Disorder
___ Tendinitis
___ Whiplash
___ Varicose Veins

If any of the above conditions need further detail or if you have anything else to share, please do so: _____
____

Do you have any of the following today:

___ Anything Contagious ___ Cold/Flu ___ Severe Pain
___ Bruises/Injuries ___ Open Cuts/Wounds ___ Skin Rash

Do you have any allergies to any of the following:

___ Environment Allergen (dust, pollen, fragrances) ___ Medications
___ Foods (nuts, vegetables) ___ Skin Care Products

If any of the above allergens are **X**, please give details:____

____

Are you wearing: ___ Contact Lenses ___ Hearing Aid ___ Hairpiece

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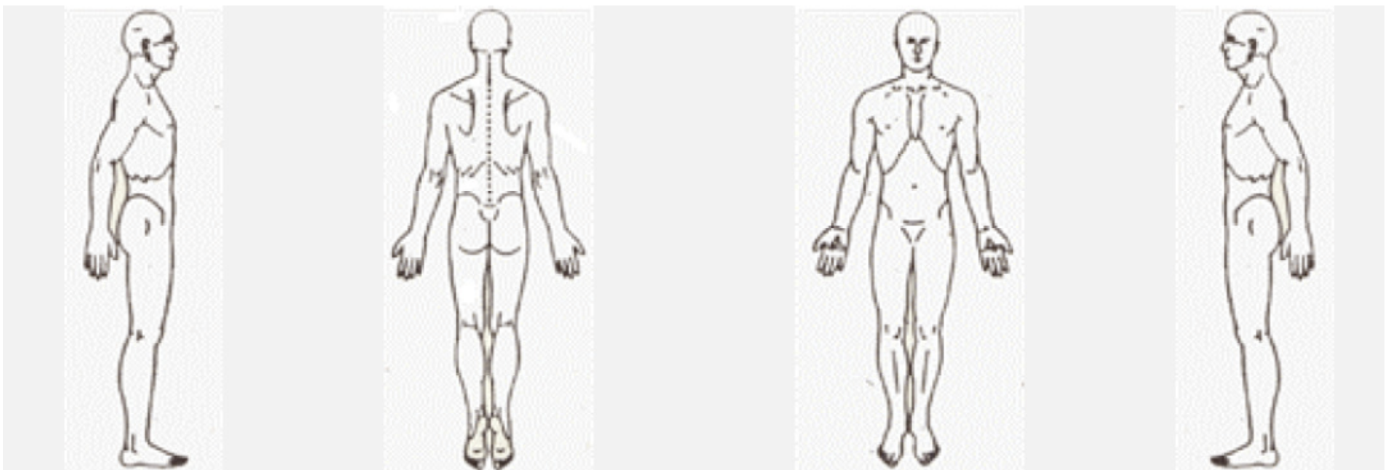
Please indicate with an **X or Circle** (if any) the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? ____________________________________

The following sometimes occur during massage:

- the need to move or change position
- sighing, yawning, change in breathing
- stomach gurgling
- movement of intestinal gas
- emotional feelings and/or expression
- energy shifts
- falling asleep
- memories

Please read the following information and sign below:

1. I understand that, although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and ANY sexual remarks or advances will terminate the session and I (client) will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: ____ **Date:** ______________________