

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

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.

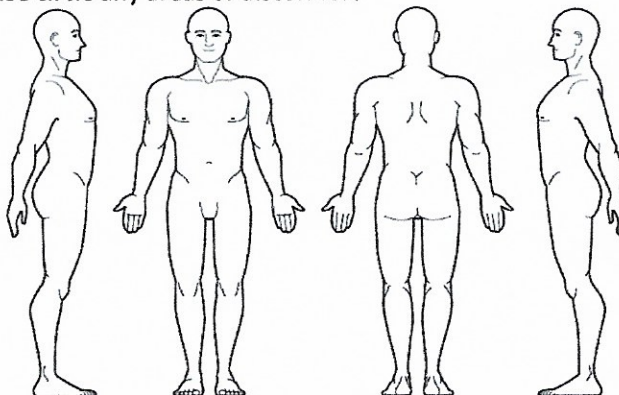
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|--|---|
| ☐ Cancer | ☐ Fibromyalgia |
| ☐ Headaches/Migraines | ☐ Stroke |
| ☐ Arthritis | ☐ Heart Attack |
| ☐ Diabetes | ☐ Kidney Dysfunction |
| ☐ Joint Replacement(s) | ☐ Blood Clots |
| ☐ High/Low Blood Pressure | ☐ Numbness |
| ☐ Neuropathy | ☐ Sprains or Strains |

Explain any conditions you have marked above:

Massage Information

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



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 _____