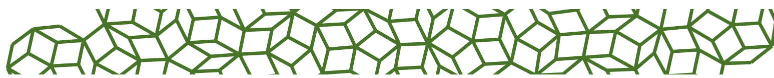
# Massage Intake Form



Name ______________________ Date of birth ______________ Phone ______________

Address ______________________ City / State / Zip ______________________

E-Mail ______________ Occupation ______________ Emergency Contact ______________

How did you hear about our services? ______________________________

**Are you currently seeing a healthcare professional?**

Physician's Name: ______________________

Physician's Contact Information: ______________

**Do you have any of the following today:**

◯ cold/flu ◯ injuries/bruises ◯ skin rash ◯ open cuts ◯ severe pain

**Are you wearing:**

◯ contact lenses ◯ hearing aid ◯ hairpiece ◯ pacemaker

**Have you ever received massage therapy?** Yes ◯ No ◯

**Are you currently taking any medications?** Yes ◯ No ◯

If yes, please list name and reason for medications

______________________________

**Please list any allergies:**

(including food, medication, seasonal, skin care products or essential oils):

______________________________

**Are you currently pregnant?** Yes ◯ No ◯

If yes please indicate your trimester, due date and any considerations:

______________________________

**Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.**

- ◯ arthritis
- ◯ diabetes
- ◯ blood clots
- ◯ broken/dislocated bones
- ◯ bruise easily
- ◯ cancer
- ◯ chronic pain
- ◯ constipation/diarrhea
- ◯ auto-immune condition*
- ◯ hepatitis (A, B, C, other)
- ◯ skin conditions
- ◯ stroke
- ◯ surgery
- ◯ TMJ disorder
- ◯ depression / panic disorder / other psych condition
- ◯ diverticulitis
- ◯ headaches
- ◯ heart conditions
- ◯ back problems
- ◯ high blood pressure
- ◯ insomnia
- ◯ muscle strain/sprain
- ◯ scoliosis
- ◯ seizures
- ◯ whiplash
- ◯ chemical dependency (alcohol, drugs)
- ◯ Other. Please explain:

______________________________

______________________________

______________________________

**What are your goals/expectations for your massage today?**

______________________________

Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully and will notify my therapist of any changes in relevant health conditions. I am aware that there is a 24 hour cancellation policy. I realize that if I forget my appointment or cancel within less than 24 hours I am responsible for paying the fee in full.

Date: ______________ Signature: ______________

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