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 Inforn	nation
Are you taking any medications? \qed yes	□ no Have you had a pr	ofessional massage before? \square yes \square no
If yes, please list name and use:	What type of mass	sage are you seeking?
	🗆 🗆 Relaxa	tion
Are you currently pregnant? \qed 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? \qed yes	\sqsupset no \Biggr Do you have any a	llergies or sensitivities? \Box yes \Box no
If yes, please explain	Please explai	in
What makes it better?	want massaged?	is (feet, face, abdomen, etc.) you do not uges uges no in
What makes it worse?		als for this treatment session?
Have you had any orthopedic injuries? ☐ yes ☐ If yes, please list:	□ no Please circle any a	reas of discomfort $\mathcal{F}_{\mathfrak{P}}$
Please indicate any of the following that apply to you Cancer Fibromyalgia Headaches/Migraines Stroke Arthritis Heart Attack Diabetes Kidney Dysfunct Joint Replacement(s) Blood Clots High/Low Blood Pressure Numbness Neuropathy Sprains or Strain Explain any conditions you have marked above:	By signing below, y I have completed th	ou agree to the following. This form to the best of my ability and knowledge in my therapist if any of the above information e.
	Client Signature	Date
	Thoranist Signature	Data