Massage Intake Form

Personal Information

Name ______ Date of Birth ______

Address ______

City ______ State ______ Zip Code ______

Primary Phone ______ Secondary Phone ______

Email ______

Occupation ______ Employer ______

Marital Status ______ If marries, spouses name ______

Referred By ______

Emergency Contact ______ Phone ______

Massage Experience

Have you had a professional massage before?

☐ Yes ☐ No If yes, what types of massage have you had?

☐ Swedish ☐ Shiatsu ☐ Deep Tissue

☐ Other ______

What are your goals for treatment? ______

Current Health

Reason for initial visit ______

Do you exercise regularly and/or participate in any sports?

☐ Yes ☐ No If yes, what kind of exercise/sports? ______

Do you perform any repetitive movements in work, sports, or hobby?

☐ Yes ☐ No If yes, describe ______

Do you sit for long hours at a workstation, computer or driving?

☐ Yes ☐ No If yes, describe ______

Are you experiencing tension, stiffness, discomfort, or pain?

☐ Yes ☐ No If yes, describe ______

Have you recently had an injury, surgery, or areas of inflammation?

☐ Yes ☐ No If yes, describe ______

Do you have any allergies to oils, lotions, or ointments?

☐ Yes ☐ No If yes, describe ______

Health History

Musculoskeletal

☐ Bone or joint disease
☐ Tendonitis/Bursitis
☐ Arthritis/Gout
☐ Jaw Pain (TMJ)
☐ Lupus
☐ Spinal Problems
☐ Migraines/Headaches
☐ Osteoporosis

Circulatory

☐ Heart Condition
☐ Phlebitis/Varicose Veins
☐ Blood Clots
☐ High/Low Blood Pressure
☐ Lymphedema
☐ Thrombosis/Embolism

Respiratory

☐ Breathing Difficulty/Asthma
☐ Emphysema
☐ Sinus Problems
☐ Allergies, specify:

Nervous System

☐ Shingles
☐ Numbness/Tingling
☐ Pinched Nerve
☐ Chronic Pain
☐ Paralysis
☐ Multiple Sclerosis
☐ Parkinson's Disease

Skin

☐ Rashes
☐ Cosmetic Surgery
☐ Athlete's Foot
☐ Herpes/Cold Sores
☐ Allergies, specify:

Digestive

☐ Irritable Bowel Syndrome
☐ Bladder/Kidney Ailment
☐ Colitis
☐ Crohn's Disease
☐ Ulcers

Reproductive

☐ Pregnant
If so, stage:
☐ Ovarian/Menstrual Problems
☐ Prostate

Psychological

☐ Anxiety/Stress Syndrome
☐ Depression

Other

☐ Cancer/Tumors
☐ Diabetes
☐ Drug/Alcohol/Tobacco Use
☐ Contact Lenses
☐ Dentures
☐ Hearing Aids

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

SIGNATURE ______ **DATE** ______

CANCELLATION POLICY: You may cancel without charge up to **24 hours** preceding your appointment. Same day cancellations will be charged $50.