Massage Intake Form

Personal Information

Name_____ Phone _____
Address_____ City/State/Zip_____
Occupation_____ DOB_____
Emergency Contact_____ Phone_____
How do you prefer to be contacted? Call_____ Text_____ either one_____
Email:_____ Referred by:_____

Medical Information

Are you taking any medications? _____yes _____ no
If yes, please list name & 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? _____

Please indicate if any of the following apply to you:

__cancer __fibromyalgia __headaches/ migraines __arthritis
__stroke __heart attack __diabetes __kidney problems
__skin conditions __TMJ disorder __numbness __high/low blood pressure
__sprains/strains __joint replacements
__neck/back injuries __recent injuries __blood clots

Explain any conditions you have marked above:_____
_____
_____
_____

(Continued on next page.)

Massage Information

Have you had a professional massage before? _____ yes _____ no

What type of massage are you seeking? ____relaxation _____deep tissue _____both

What pressure do you prefer? _____light _____medium _____deep

Do you have any allergies or sensitivities? _____ yes _____ no

Please explain: _____

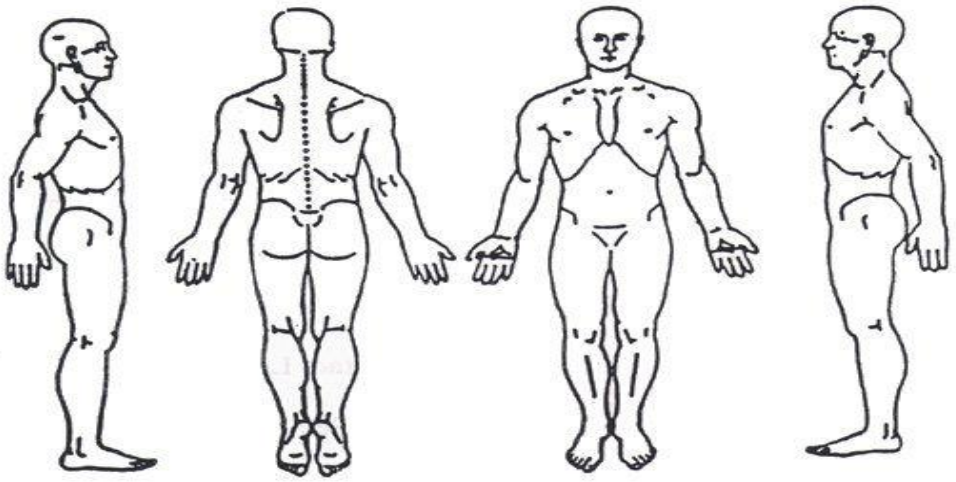
Are there any areas (feet, face, abdomen, etc) you do not want massaged?

_____

What are your goals for this treatment session? _____

_____

Please circle any areas of discomfort:



I understand that the massage given to me by ***Massage by KT*** is for the purpose of stress reduction, pain reduction, relief from muscle tension, or increased circulation.
I understand that the massage therapist does not diagnose illness and does not prescribe medical treatment.
I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with a primary caregiver for any conditions I may have.

By signing below you agree to the following:

I have completed this form to the best of my ability and knowledge and I agree to inform my therapist f any of the above information changes at any time.

Client Signature_____ Date_____

Therapist Signature_____ Date_____