Massage Intake Form

Personal Information

Name _____ Date _____

Address _____ City/State/Zip _____

DOB ___/___/___ Phone_____ Occupation_____

Medical Information

Are you taking any medications? Yes___ No___ If yes, please list name and use:

_____

Do you have any allergies? Yes___ No___
If yes, please list name and use:

_____

Are you currently pregnant? Yes___ No___
If yes, how far along? _____

Do you suffer from chronic pain? Yes___ No___
If yes, please explain _____
What makes it better?

_____

What makes it worse?

_____

Have you had a professional massage before?
Yes___ No___

Massage Information

What type of massage are you seeking?
Relaxation ___ Therapeutic/Deep Tissue___
Other _____

What pressure do you prefer?
Light___ Medium___ Deep___

Are there any areas you want focused on?
Yes__ No___
Please explain _____

Are there any areas you do not want massaged?
Yes___ No___

Please explain _____

What are your goals for this treatment session?

_____

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.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____

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