



Massage Intake Form

Date: _____

Confidential Information

Welcome! I would like to make your massage as pleasant and comfortable as possible. If at any time you have questions regarding your session, please let me know.

*** PLEASE PRINT CLEARLY ***

Name _____ DOB _____ Male _____ Female _____

Address _____ City _____ State _____ Zip _____

Primary Phone (circle one: Home - Cell - Work) _____

E-mail (appt. reminders/specials) _____

Referred by _____

Occupation _____

Emergency Contact _____ # _____

Have you ever received massage therapy? Yes _____ No _____ If yes, how often? _____

Are you currently taking any medications? Yes _____ No _____

If yes, please list medications by name and purpose _____

Please list any allergies you may have _____

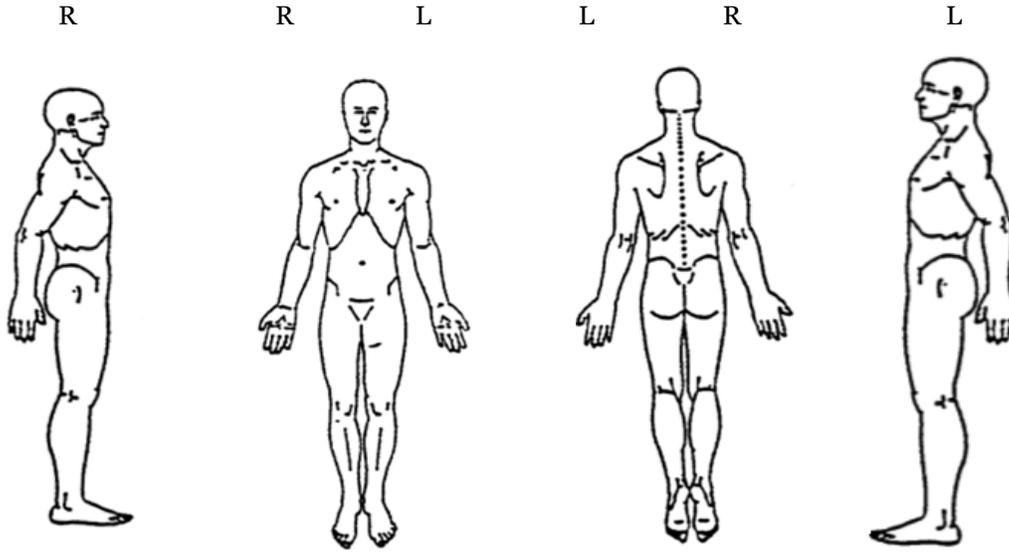
What are your goals/expectations for this massage therapy session? _____

Additional comments/concerns _____

Check the following conditions that apply to you:

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Difficulty Concentrating	<input type="checkbox"/>	Infectious Disease	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Allergies/Sinus Problems	<input type="checkbox"/>	Joint Stiffness/Swelling	<input type="checkbox"/>	Cold/Flu	<input type="checkbox"/>	Anything Contagious
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Low/High Blood Pressure	<input type="checkbox"/>	Muscle Spasms/Cramps	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	Rashes/Warts/Open Cuts	<input type="checkbox"/>	Currently Pregnant
<input type="checkbox"/>	Other:						

Please Indicate The Areas In Which You Are Feeling Discomfort:



I, _____, (client) understand that massage is intended to enhance relaxation, reduce pain caused by muscle tension, improve circulation and offer a positive experience of touch. I understand that massage therapy is not a substitute for medical treatment or medication and that it is recommended that I concurrently work with my primary caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease and does not prescribe medications. I understand this is a therapeutic massage and any sexual remarks for advances will terminate the session and I will be liable for payment of the scheduled treatment.

I have informed the massage therapist of all my known physical and medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part should I fail to do so.

Initial:

_____ I understand it is my responsibility to show up on time for an appointment, failure to do so will result in loss of time.

_____ If for any reason I cannot make it for an appointment, I understand a 24-hour cancellation notice is required.

Client Signature _____ Date _____

Clients under the age of 18 must have permission from a parent/legal guardian.

x _____ Relationship _____

