

# 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

Are you taking any medications?  yes  no

If yes, please list name and 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? \_\_\_\_\_

Have you had any orthopedic injuries?  yes  no

If yes, please list: \_\_\_\_\_

Please indicate any of the following that apply to you.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |

Explain any conditions you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Massage Information

Have you had a professional massage before?  yes  no

What type of massage are you seeking?

- Relaxation  Therapeutic/Deep Tissue

Other \_\_\_\_\_

What pressure do you prefer?

- Light  Medium  Deep

Do you have any allergies or sensitivities?  yes  no

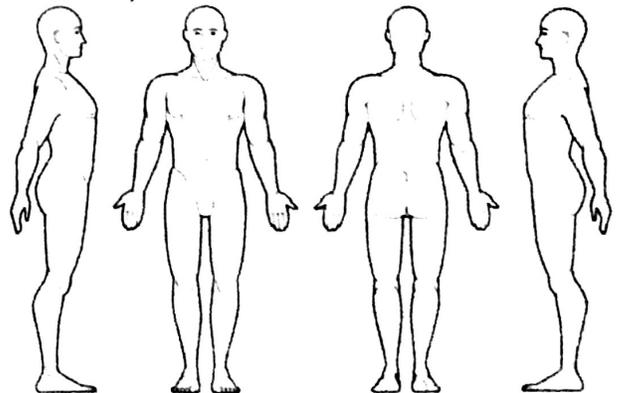
Please explain \_\_\_\_\_

Are there any areas (feet, face, abdomen, etc.) you do not want massaged?  yes  no

Please explain \_\_\_\_\_

What are your goals for this treatment session?

Please circle any areas of discomfort



By signing below, you agree to the following.

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.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

## General Liability Release Form

By signing below, you agree to the following:

- 1) I give my permission to receive massage therapy.
- 2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
- 3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
- 4) I have clearance from my physician to receive massage therapy.
- 5) I understand the risks associated with massage therapy include, but are not limited to:
  - Superficial bruising
  - Short-term muscle soreness
  - Exacerbation of undiscovered injury

I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

- 6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
- 7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.
- 8) I understand that I or the massage therapist may terminate the session at any time.
- 9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date