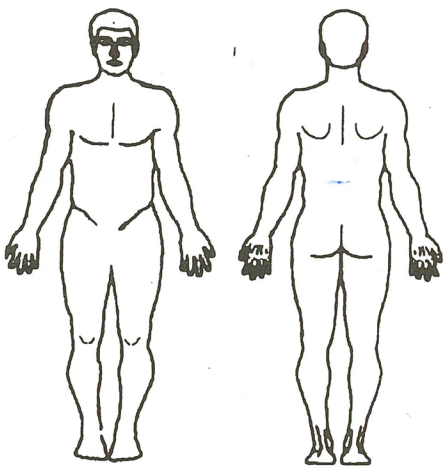
Massage Intake Form

Name:	Date:
Address:	Email:
City/State/Zip:	
Phone(Day):	Phone(Evening):
Date of Birth:	Referred by:
Reason for appointment:	
Current medications, including aspirin, ibuprofen, etc.:	

Please check all conditions that apply now or in the past, and give details below.

- ☐ Bone or muscle injuries (including sprains and strains)
- ☐ Arthritis, tendonitis
- ☐ Muscle or joint pain
- ☐ Headaches, head injuries
- ☐ Numbness, tingling
- ☐ Jaw pain, TMJ disorder
- ☐ Chronic pain
- ☐ Fatigue
- ☐ Depression
- ☐ Pregnancy
- ☐ Infectious disease
- ☐ Diabetes
- ☐ Rashes, athletes foot
- ☐ Digestive problems (includes constipation & diarrhea)
- ☐ Sleep difficulties
- ☐ Heart or lung conditions
- ☐ Varicose veins
- ☐ Blood clots
- ☐ High/low blood pressure
- ☐ Sinus problems
- ☐ Allergies, sensitivities (including skin allergies)
- ☐ Cancer, tumors
- ☐ Other conditions

Circle all areas which are painful on the picture below.



Explanation of above:

_____

_____

Do you have any other conditions of which we should be aware, including surgeries and accidents? If yes, please explain:

_____

_____

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation and energy flow. I understand that massage therapists do not diagnose illness, or disease, nor do they prescribe any medical treatments. I acknowledge that I see health care provider for that service. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the scheduled appointment. I have stated all medical conditions and will update the massage practitioner with any changes in my health status.

Signature:	Date: