

### Massage Intake Form - CONFIDENTIAL INFORMATION

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

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

State \_\_\_\_\_ City \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Have you ever received massage therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.) \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list name and reason for medications \_\_\_\_\_

\_\_\_\_\_

Are you currently seeing a healthcare professional? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list names and reason/treatment \_\_\_\_\_

\_\_\_\_\_

Please review this list and check those conditions that have affected your health either recently or in the past. Place a check mark next to the condition.

- |                                                     |                                                                  |
|-----------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> arthritis                  | <input type="checkbox"/> depression, panic disorder, other psych |
| <input type="checkbox"/> diabetes                   | <input type="checkbox"/> condition                               |
| <input type="checkbox"/> blood clots                | <input type="checkbox"/> diverticulitis                          |
| <input type="checkbox"/> broken/dislocated bones    | <input type="checkbox"/> headaches                               |
| <input type="checkbox"/> bruise easily              | <input type="checkbox"/> heart conditions                        |
| <input type="checkbox"/> cancer                     | <input type="checkbox"/> back problems                           |
| <input type="checkbox"/> chronic pain               | <input type="checkbox"/> high blood pressure                     |
| <input type="checkbox"/> constipation/diarrhea      | <input type="checkbox"/> insomnia                                |
| <input type="checkbox"/> auto-immune condition*     | <input type="checkbox"/> muscle strain/sprain                    |
| <input type="checkbox"/> hepatitis (A, B, C, other) | <input type="checkbox"/> pregnancy                               |
| <input type="checkbox"/> skin conditions            | <input type="checkbox"/> scoliosis                               |
| <input type="checkbox"/> stroke                     | <input type="checkbox"/> seizures                                |
| <input type="checkbox"/> surgery                    | <input type="checkbox"/> whiplash                                |
| <input type="checkbox"/> TMJ disorder               | <input type="checkbox"/> chemical dependency (alcohol, drugs)    |

(\*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share,

please do so: \_\_\_\_\_

\_\_\_\_\_

Do you have any of the following today:

\_\_\_\_\_ skin rash    \_\_\_\_\_ cold/flu    \_\_\_\_\_ open cuts    \_\_\_\_\_ severe pain  
\_\_\_\_\_ anything contagious    \_\_\_\_\_ injuries/bruises

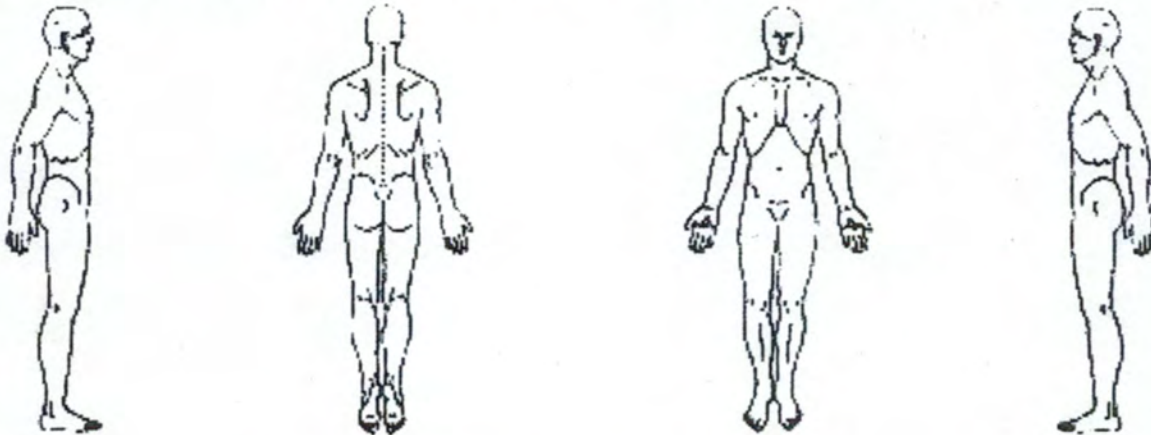
Do you have any allergies to:

\_\_\_\_\_ medications    \_\_\_\_\_ foods (nuts, etc.)  
\_\_\_\_\_ environmental allergens (dust, pollen, fragrances)  
\_\_\_\_\_ reactions to skin care products

If any of the above are checked, please give details: \_\_\_\_\_

Are you wearing: \_\_\_\_\_ contact lenses    \_\_\_\_\_ hearing aid    \_\_\_\_\_ hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? \_\_\_\_\_

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:  
need to move or change position ❖ sighing, yawning, change in breathing  
stomach gurgling ❖ emotional feelings and/or expression  
movement of intestinal gas ❖ energy shifts ❖ falling asleep ❖ memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: \_\_\_\_\_ Date \_\_\_\_\_