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** ______________ **Zip**__________ **Home Phone** ________________________

Work Phone____________ **Cell Phone** _____________ **Occupation** _______________________

Email Address ____

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 __________________________________

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Are you currently seeing a healthcare professional? ______ **Yes** ______ **No**

If yes, please list names and reason/treatment ______________________________________

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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.

- ☐ arthritis
- ☐ diabetes
- ☐ blood clots
- ☐ broken/dislocated bones
- ☐ bruise easily
- ☐ cancer
- ☐ chronic pain
- ☐ constipation/diarrhea
- ☐ auto-immune condition*
- ☐ hepatitis (A, B, C, other)
- ☐ skin conditions
- ☐ stroke
- ☐ surgery
- ☐ TMJ disorder
- ☐ depression, panic disorder, other psych
- ☐ condition
- ☐ diverticulitis
- ☐ headaches
- ☐ heart conditions
- ☐ back problems
- ☐ high/low blood pressure
- ☐ insomnia
- ☐ muscle strain/sprain/tendonitis
- ☐ pregnancy
- ☐ scoliosis
- ☐ seizures
- ☐ whiplash
- ☐ 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: ____

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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: ___________________________________

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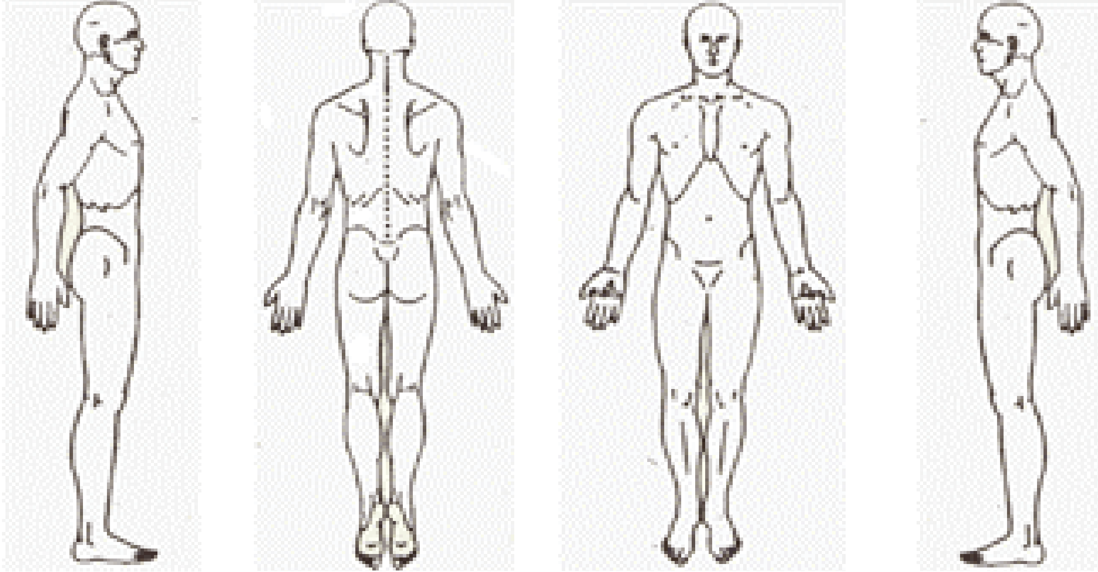
Are you wearing: ☐contact lenses ☐hearing aid ☐hairpiece

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



What are your goals/expectations for this therapy session? _____________________________

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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
- ☞ 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.
4. I understand that if the massage therapist starts a session late, she will make it up to me at the end of my session, if possible, or will reduce my fee accordingly.
5. I understand that if I arrive late, my session will end at the originally scheduled time, so the client following me is not penalized.
6. I agree to give 24-hour notice for a scheduled session that I can not keep. I am aware that I may be charged the full fee for any missed sessions or for sessions that I do not give 24-hour notice to cancel or reschedule.

Signature: ____ Date _________________