

Massage Intake Form

Welcome to



Our goal is to deliver the best experience possible. To customize your experience and exceed your expectations please complete the questions below. For the following categories, please circle all that apply.

Name: _____

Email: _____

Cell Phone: _____

Mailing Address: _____

Date of Birth: _____ Anniversary date _____

Occupation: _____ Referred by: _____

Preferred Method of Contact: Phone Email

Would you like Appointment Reminders sent to your Cell Phone? Yes or No

For Face

What are your concerns?

Dry Skin Dehydration Allergies Sinus Pressure

For Body

What are some of your concerns?

Muscle Tension Stress Discomfort Dry skin Cellulite
Circulation Sunburned Arthritis Soreness Numbness
Poor Posture Digestive issues

Desired Massage Pressure Light Firm Deep Tissue

For Hands & Feet

Age Spots Dry Skin Dry Cuticles Callous
Fragile/Brittle Nails Soreness Flat Feet Muscle Tension

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It is not advisable to engage in certain treatments where specific medical conditions exist.

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

- | | | |
|--------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression, panic disorder, other psych condition | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hepatitis (A, B, C, etc.) |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Broken/dislocated bones | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High/ Low blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Spinal Injuries | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Muscular Disorder | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> TMJ disorder | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Auto- Immune condition* |
| <input type="checkbox"/> Vertigo | *AIDS, Lupus, Rheumatoid Arthritis, etc. | |

If any of the above needs to be detailed or if there is anything not listed, please explain:

Do you have any allergies? (Cosmetics, ingredients, food, iodine, medications, latex, etc.)

No Yes (Please specify) _____

Are you currently undergoing chemotherapy or radiation therapy?

No Yes (Please specify) _____

Are you currently taking any medications, herbs, or vitamins? (Internal or Topically)

No Yes (Please specify) _____

Is there anything else we should know that may affect your treatment?

Other (Please specify) _____

Have you had or currently have any of the following within the last 5 days?

Skin rash Cold/Flu/ Open cuts Injuries/bruises
 Anything contagious Severe pain: _____

Women only Do any of the following pertain to you currently?

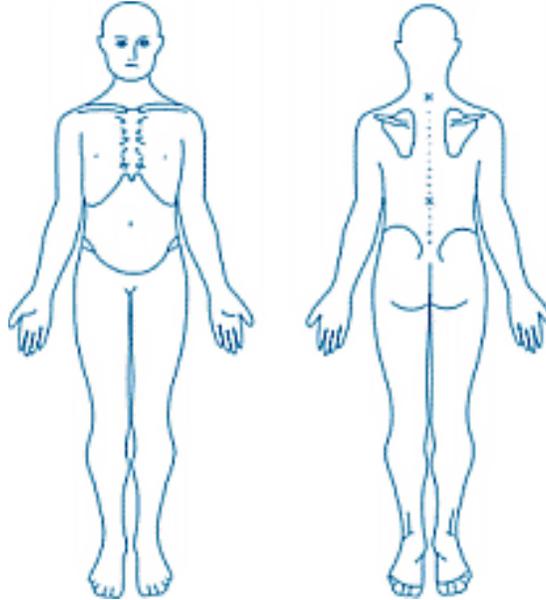
Hormonal Problems Pregnant Lactating
 Menopause Hormonal Birth Control Regular Menstruation

Are you currently wearing: contact lenses hearing aid hairpiece

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Please record any injuries, surgeries, or accidents and when they occurred (month/year)

Please **circle** the areas in which you are feeling pain/discomfort, if any:



If you could improve one thing today what would it be?

Please read the following and sign below:

1. I understand that although massage therapy is very therapeutic, relaxing, and is designed to address my concerns, it is not a substitute for medical examination, diagnosis and treatment. Never discontinue use of any medications or treatments without direct consent from your treating physician.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session immediately and I will be liable for full payment of the scheduled treatment.
3. All massage treatments should not be performed under certain medical conditions; therefore, I affirm that I have answered all questions pertaining to medical conditions and treatments thoroughly and truthfully.

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____