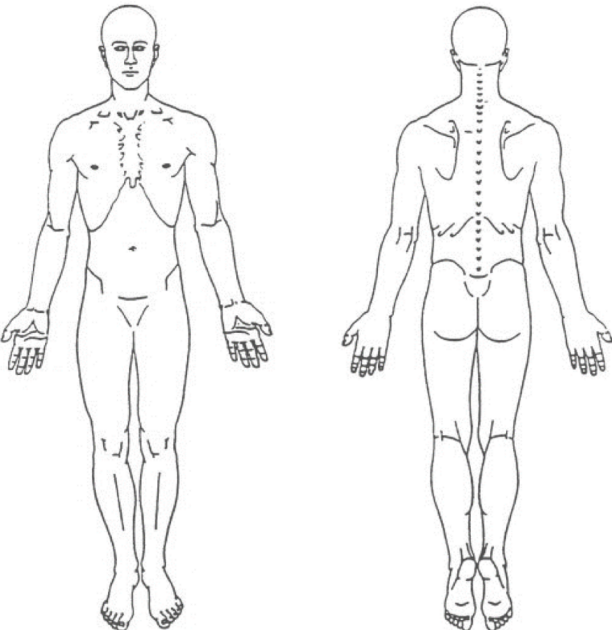


Massage Intake Form

Personal Information				
First Name	Last Name	Date of Birth	Gender	
Address		City	State	Zip Code
Contact Number		Email		
Emergency Contact				
Full Name	Relationship		Contact Number	
Full Name	Relationship		Contact Number	
Medical Information				
Please list any medical conditions or health problems you have had in the past or present:				
Are you taking any medications?			☐ Yes ☐ No	
If yes, please specify:				
Do you suffer from chronic pain?			☐ Yes ☐ No	
If yes, please explain: (including what makes it better or worse)				
Have you had any orthopedic injuries?			☐ Yes ☐ No	
If yes, please list:				
Massage Information				
Have you had a professional massage before?				
☐ Yes ☐ No				
What type of massage are you seeking				
☐ Relaxation ☐ Therapeutic/Deep Tissue ☐ Other: _____				
Do you have any allergies or sensitivities?			☐ Yes ☐ No	
If yes, please explain:				
Are there any areas (feet, face, abdomen, etc.) you do not want massaged?			☐ Yes ☐ No	
If yes, please explain:				

Personal Information			
First Name	Last Name	Date of Birth	Gender
Massage Information (Continued)			
What are your goal for this treatment session?			
Please indicate or describe any area of discomfort:			
		✕ Adhesion ↻ Rotation ○ Pain ● Tender Joint ≡ Hypertonicity ≈ Spasm ⦿ Inflammation 9 Trigger Point / Elevation	
Insurance			
Insurance Carrier	Insurance Plan	Contact Number	
Policy Number	Group Number	Social Security Number	
Authorization			
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 change at any time.			
_____ Client Signature		_____ Date	
_____ Therapist Signature		_____ Date	