



MASSAGE INTAKE FORM

Name: _____ Age: _____

Occupation/Employer: _____

Have you ever received a professional massage? YES _____ NO _____

Do you exercise? YES _____ NO _____ Do you stretch regularly? YES _____ NO _____

Personal Medical History? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Tendinitis Location? _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bursitis Location? _____ |
| <input type="checkbox"/> Heart Condition: Explain _____ | <input type="checkbox"/> Metal Implant |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Frequent Headaches: (Migraines? Y N) | <input type="checkbox"/> Other: _____ |

Is there a possibility you may be pregnant? YES _____ NO _____

Are you currently taking any medications? YES _____ NO _____

If YES, please explain: _____

Where do you experience pain or discomfort? (Please check all that apply)

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Back |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Arms/Hands |
| <input type="checkbox"/> Legs/Feet | |

It is my choice to receive Massage Therapy. I realize that the treatment is being given for the well being of my mind and body. This includes stress reduction, relief from muscular tension, spasm or pain, pain for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel my well being is being compromised. I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals or spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary healthcare provider for such services. I have stated above of all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Signature: _____ Date: _____