Massage Intake Form

Name _____ Today's Date _____

Home Address _____

Cell Phone _____ Work / Home Phone_____

Email Address_____
Would you like to receive monthly newsletter? Yes / No

Date of Birth _____

Gender_____ Preferred Pronoun _____
(We ask as a means of respecting the spectrum of gender identities.)

Occupation_____

Emergency Contact Name and Number _____

Primary Health Concern(s) _____
_____

GENERAL INFORMATION

Are you pregnant? Yes / No
Do you have a pacemaker? Yes / No
Do you have high/low blood pressure, varicose veins, or faint easily? Yes / No
Do you have sensitive skin? Yes / No
Do you have any allergies to oils, lotions or ointments? Yes / No
if yes describe: _____
Do you exercise regularly and/or participate in any sports? Yes / No
If yes, what kind of exercise/sports?_____
Do you perform any repetitive movement in your work, sports or hobby? Yes / No
If yes, describe_____

Do you sit for long hours at a workstation, computer or driving? Yes / No
If yes, describe_____

Do you experience stress in your work, family, or other aspect of your life? Yes / No
If yes, describe_____

Are you experiencing tension, stiffness, discomfort or pain? Yes / No
If yes, describe_____

Have you recently had an injury, surgery, or areas of inflammation? Yes / No
If yes, describe_____

Have you had a professional massage before? Yes / No
If yes, what types of massage have you had (swedish, shiatsu, deep tissue, etc.)?
_____

Thank you for your time and patience in completing this form.

Patient Information & Informed Consent Agreement

I understand that massage treatments given to me by the therapist are for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, and/or other health related reasons stated.

I understand that massage treatments rendered are medically-based and not for the purpose of sensual and/or sexual pleasures.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is complementary to western medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

I understand that should the practitioner feel professional boundaries have been violated during the treatment, they reserve the right to terminate the session.

Signed consent for treatment:
I have read the above information and agree to treatment.

Name: _____ Date: _____
Signature: _____
Parent Signature (if minor under age 18): _____