Massage Intake Form - CONFIDENTIAL INFORMATION

WELCOME! I would like to make your appointment as pleasant and comfortable as possible. If at a time you have questions regarding your session, please let me know.

Name____ Date of birth____________________

Address____

State__________ City______________________________ Home Phone______________________

Cell Phone______________________________ Occupation_____________________________

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 year. Place a check mark next to the condition.

____arthritis

____diabetes

____broken/dislocated bones

____headaches

____heart conditions

____back problems

____high blood pressure

____insomnia

____muscle strain/sprain

____pregnancy

____scoliosis

____seizures

____whiplash

____chemical dependency (alcohol, drugs)

____depression, panic disorder, other psych condition

____diverticulitis

____blood clots

____bruise easily

____cancer

____chronic pain

____constipation/diarrhea

____auto-immune condition*

____hepatitis (A, B, C, other)

____skin conditions

____stroke

____surgery

____TMJ disorder

(*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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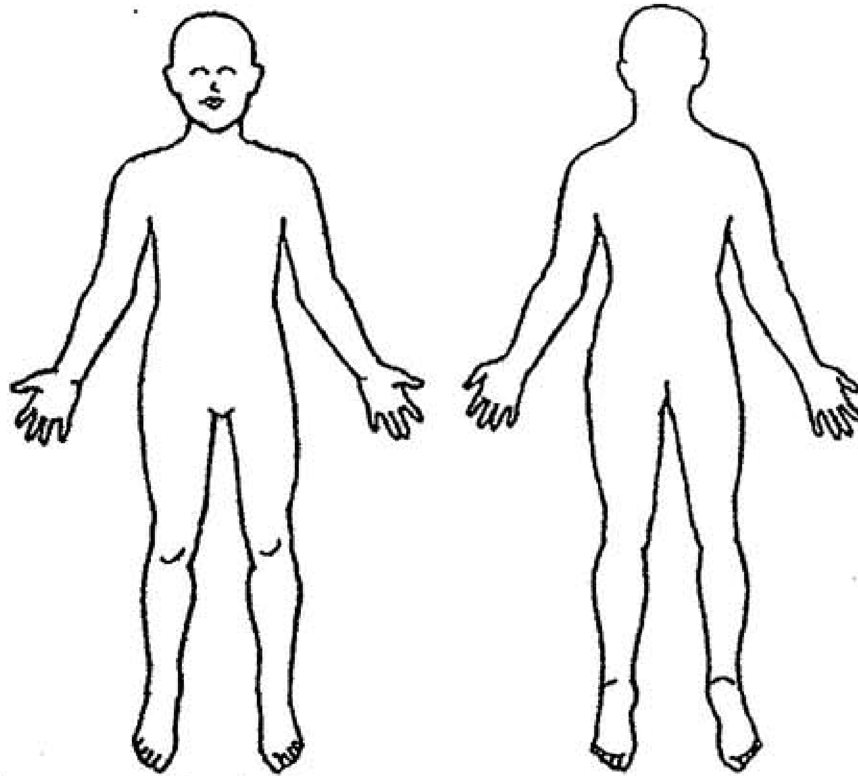
Do you have any of the following today: ______skin rash ______cold/flu ______fever
______open cuts ______severe pain ______anything contagious ______injuries/bruises

Do you have any allergies to: ______medications ______food (nuts, etc.)
______environmental allergens (dust, pollen, fragrances) ______reactions to skin care products.

If any of the above are checked, please give details: ____________________
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 and/or expression
movement of intestinal gas ❖ energy shifts ❖ falling asleep ❖ memories

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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.

Signature____________________ Date____________________

Witness Signature____________________ Date____________________

7/08
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