Massage Intake Form

Name: ______________________ Cell Phone: ______________________

Address: ______________________ City: ______________________

State: __________ Zip: __________ D.O.B: ______________________

Email Address: ______________________

Occupation: ______________________ Referred by: ______________________

Emergency Contact: ______________________ Phone: ______________________

Current Medications: ______________________

Primary Reason for your visit today: ______________________

Do you have any of the following today?

______ Sunburn _____ Open cuts ____ Cold/flu ____ Pregnant
______ Inflammation _____ Headache ____ Irritated skin #weeks______
______ Severe pain _____ Allergies ____ Other ______________________

Do you have a history of any of the following?

______ Diabetes _____ Sprains ____ Fractures
______ Neck Pain _____ Seizures ____ Varicose Veins
______ Whiplash _____ Arthritis ____ Bursitis
______ Back pain _____ Stroke ____ Heart attack
______ Joint pain _____ Cancer ____ Neuropathy
______ High/Low Blood Pressure ____ Other ______________________

Are you wearing any of the following?

______ Hearing Aids _____ Contacts ____ Hair piece

Any sensitivity to essential oils? _________________

Please read the following and sign below.

I understand that massage is not a substitute for medical treatment.

I will report any changes in my health or medications to my therapist at each visit.
I am aware that close contact increases the risk of transmission of airborne illnesses and I accept that risk.

If I have any reason to suspect that I am ill, I will reschedule with as much notice as possible.
I understand that I am responsible for payment, in full, for missed appointments that have not been cancelled or rescheduled ahead of time.

______________________ ______________________
Client Signature Date
(If under 18, Parent must sign.)

______________________ ______________________
Therapist signature Date