Massage Intake Form

Personal Information

First Name	Last Name	Date of Birth	Gender
Mark	Sample	09/21/1970	Male

Address	City	State	Zip Code
123 Example Street	New York	NY	123-456

Contact Number	Email
000 - 123 - 456	mark.sample@example.com

Emergency Contact

Full Name	Relationship	Contact Number
Mia Sample	Wife	000 - 000 - 000
Full Name	Relationship	Contact Number

Medical Information

Please list any medical conditions or health problems you have had in the past or present:
I have had problems with my back for a long time. I work in construction and heavy labor has injured my back. It constantly aches and I find it hard to sleep sometmes.

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:

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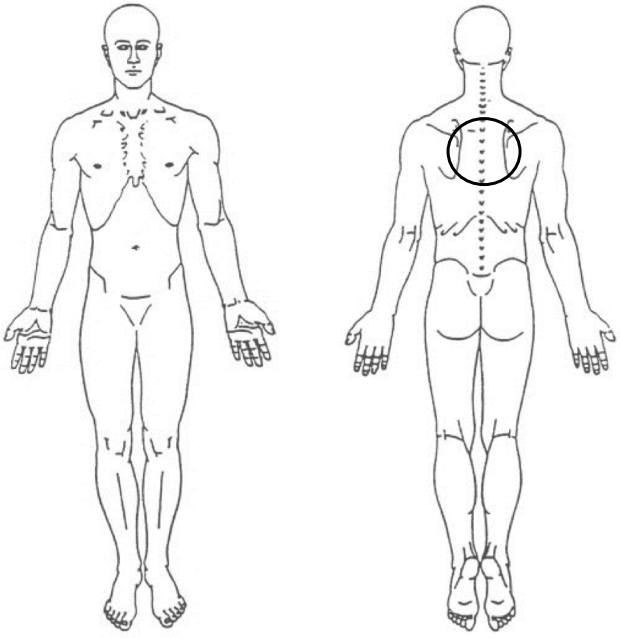
Massage Information (Continued)

What are your goal for this treatment session?

I want the massage to help ease the ache in my back.

Please indicate or describe any area of discomfort:



- Adhesion
- Rotation
- Pain
- Tender Joint
- Hypertonicity
- Spasm
- Inflammation
- Trigger Point
- Elevation

Insurance

Insurance Carrier	Insurance Plan	Contact Number
		000 - 123 - 456
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: 12/03/2022

Therapist Signature — Date: 12/04/2022