Massage Therapy Intake Form

Name:

Date of Birth:

Address:

Phone:

E-mail:

Occupation and Employer

Emergency Contact & Relationship:

MEDICAL INFORMATION
Are you pregnant? ☐ Yes ☐ No
If yes, how far along, and please elaborate if you have any high-risk factors.
Are you sensitive to touch or pressure? Are you ticklish? ☐ Yes ☐ No
If yes, which area?
Do you suffer from chronic pain? ☐ Yes ☐ No
If yes, please elaborate. What makes it better or worse?
Have you had any orthopedic injuries? ☐ Yes ☐ No

If yes, please elaborate.

Do you have any allergies or sensitivities?

- [ ] Yes
- [ ] No

If yes, please elaborate.

Please list down any medications you take and what they're for:

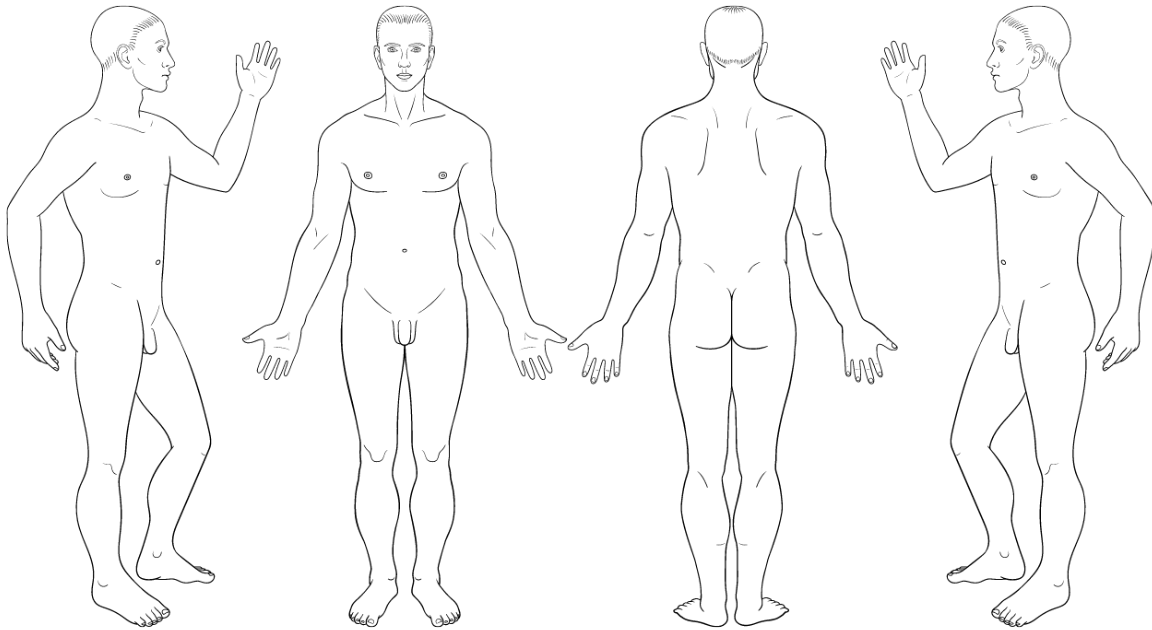
Please list down orthopedic injuries and surgeries you had. If possible, add the type and date:

Please check all that apply to you:

- [ ] Skin conditions
- [ ] Lymphatic condition
- [ ] Bone condition
- [ ] Circulatory Conditions like high or low blood pressure, blood clots
- [ ] Joint Replacements or Problems like arthritis
- [ ] Headaches/Migraines
- [ ] Diabetes
- [ ] Numbness/Tingling
- [ ] Cancer
- [ ] Neuropathy
- [ ] Stroke or Heart Attack
- [ ] Kidney Dysfunction
- [ ] Sprains or Strains
- [ ] Other: ____

If you checked any of the above, please elaborate:

What areas do you not want to be massaged, if any?

What are your goals for this treatment session?

Please mark or point to the areas in the diagram where you feel pain or discomfort.

Patient's Signature:

Therapist's Signature: