Massage Intake Form

Name:_______________________________________ Date of Birth:______________

Address____

State_____ City______________ Zip___________ Phone____________________

Emergency Contact: Name_________________________ Phone____________________

Have you ever received massage therapy?________ Occupation_______________

Email:____

How did you hear about us?_______________________

What brings you here today? Relaxation Muscle Soreness Stress Other

Are you currently seeing a healthcare professional? Yes No

Please check the conditions that apply to you

Broken/Dislocated Bone___

Skin Condition___

Chronic Pain___

Whiplash___

Low/High Blood Pressure___

Heart Conditions___

Blood Clots___

On Blood Thinner___

Bruise Easy___

Headaches___

Muscle Sprain/Strain___

Pregnancy____&____Weeks

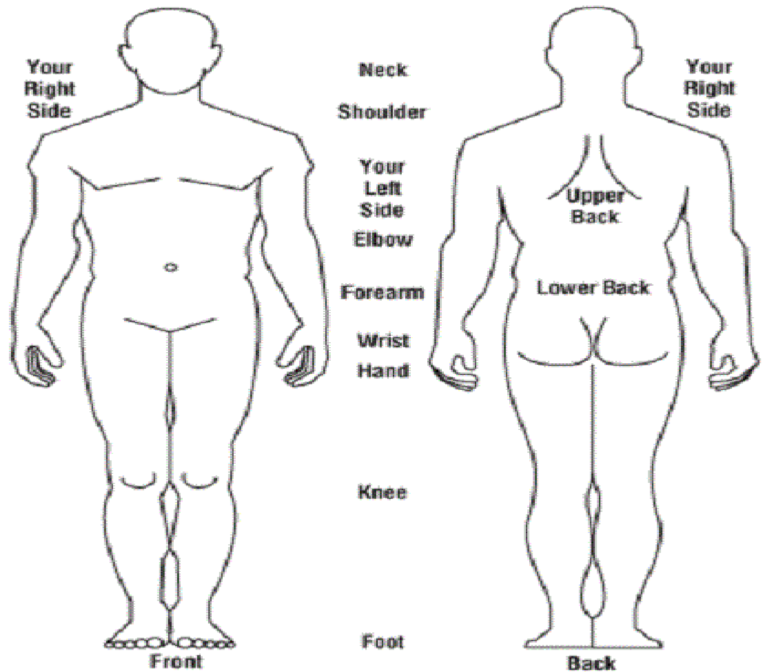
Open Cuts___

Injury___

Cold/Flu___

Anything Contagious___

Please indicate any areas of discomfort



Responses to experience during the massage may include:

●The need to move/change positions ●Signing/Yawning ●Stomach gurgling ● Emotional feelings/Memories ●Falling asleep●

I understand massage therapy can be very therapeutic, relaxing, & reduces muscle tension, but is not a substitute for medical examination & treatment.

This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for full payment.

On occasion, massage should not be done under certain medical conditions; I affirm I have answered all medical questions truthfully.

Signature______________________________________ Date_______________

Therapist______________________________________