Massage Intake Form

Name:_______________________________________ Date of Birth:______________

Address____

City_______________ State:_____ Zip___________ Phone____________________

Emergency Contact: Name_________________________ Phone____________________

Have you ever received massage therapy?________ Occupation________________

Email Address:___________________________________

Are you currently seeing a healthcare professional?______________________________

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Please check the conditions that apply to you

Injury ___

Open Cuts ___

Anything Contagious ___

Cold/Flu ___

Broken/Dislocated Bone___

Skin Condition___

Chronic Pain___

Whiplash___

Low/High Blood Pressure___

Heart Conditions___

Blood Clots___

On Blood Thinner___

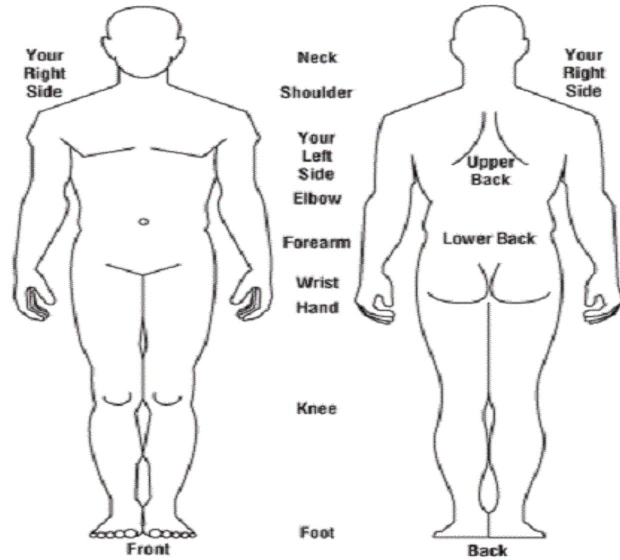
Bruise Easy___

Headaches___

Muscle Sprain/Strain___

Pregnancy____&____Weeks

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________________

Massage Therapist___________________________________

GRATUITY NOT INCLUDED