Massage Intake Form

PERSONAL INFORMATION

First name: _____ Last name: _____

Date of birth: _____ dd / mm / yyyy Gender: _____

Address: _____ City: _____

State: _____ Zip code: _____

Phone number: _____ Email: _____

EMERGENCY CONTACT

Full name: _____ Relationship: _____

Contact number: _____ Full name: _____

Relationship: _____

MEDICAL INFORMATION

Please list any medical conditions or health problems you have had in the past or present:

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.) that you do not want to be massaged?

◯ Yes ◯ No

If yes, please explain:

What are your goals for this treatment session?

Please indicate or describe any area of discomfort:

INSURANCE INFORMATION

Insurance carrier: _____ **Insurance plan:** _____

Contact number: _____ **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 name: _____

Client signature:

Date: _____ dd / mm / yyyy