



Massage Intake Form

Name: _____ Date of Birth _____

Address: _____

Home Phone _____ Work Phone: _____ Cell Phone: _____

Email _____ Occupation/Employer _____

Emergency Contact _____ Phone _____ Relationship _____

Are you currently under the care of a medical provider? _____

If yes, provider's name _____ Phone _____

Medical Conditions (please explain) _____

Massage History

Have you ever received a professional massage? Yes No
If yes, frequency: _____ Date of last massage _____

What are your goals for your massage session? _____

Check the areas of your body that you give permission to receive massage:
 Head Face Neck Chest (Pec. Muscles) Arms Hands Legs Feet
 Back Buttocks Abdomen

Current Health Concerns

Please list and check all that apply.

Primary reason for visit: _____
 Mild Moderate Disabling Constant Intermittent Worse with activity Improves with activity

Secondary reason for visit: _____
 Mild Moderate Disabling Constant Intermittent Worse with activity Improves with activity

Please list current medications/supplements/vitamins and what they are taken for:

- 1) _____ 3) _____
- 2) _____ 4) _____

Please list all surgeries and dates:

- 1) _____ 3) _____
- 2) _____ 4) _____

Please list any accidents and dates of occurrence:

- 1) _____ 3) _____
 2) _____ 4) _____

Please list any major illnesses and dates of occurrence:

- 1) _____ 3) _____
 2) _____ 4) _____

Health History

	Current	Past		Current	Past
Muscular/Skeletal			Nervous System		
Headaches	[]	[]	Head Injuries/Concussions	[]	[]
Joint Pain	[]	[]	Dizziness/Ringing in Ears	[]	[]
Muscle Pain	[]	[]	Memory loss/Confusion	[]	[]
Arthritis	[]	[]	Numbness/Tingling/Shooting Pain	[]	[]
Tendonitis	[]	[]	Sciatica	[]	[]
Broken Bones	[]	[]	Depression	[]	[]
Sprains/Strains	[]	[]	Spinal Cord Injury	[]	[]
Muscle Tension	[]	[]	Herpes/Shingles	[]	[]
Head or Neck Injury	[]	[]	Other _____	[]	[]
Shoulder or Arm injury	[]	[]	Skin		
Back injury	[]	[]	Rashes	[]	[]
Leg or foot injury	[]	[]	Open Wounds	[]	[]
Other _____	[]	[]	Athlete's Foot/Ringworm	[]	[]
Respiratory			Warts	[]	[]
Asthma/Emphysema	[]	[]	Allergies to latex/oils/lotion	[]	[]
Pneumonia	[]	[]	Other _____	[]	[]
Shortness of Breath	[]	[]	Cardiovascular/Circulatory		
Chronic Bronchitis	[]	[]	Heart Disease	[]	[]
Other _____	[]	[]	History of Blood Clots	[]	[]
Digestion			Stroke	[]	[]
Irritable Bowel Syndrome	[]	[]	Edema	[]	[]
Constipation/Diarrhea	[]	[]	Lymphedema/Lymphnode removal	[]	[]
Gas/Bloating	[]	[]	Blood Pressure high/low	[]	[]
Nausea	[]	[]	Irregular heart beat	[]	[]
Abdominal Pain	[]	[]	Poor circulation	[]	[]
Other _____	[]	[]	Swollen ankles	[]	[]
Endocrine			Varicose veins	[]	[]
Hypo/Hyperthyroid	[]	[]	Chest pain	[]	[]
Diabetes/Insulin Shots	[]	[]	Other _____	[]	[]
Reproductive	[]	[]	Infection Disease		
Pregnancy	[]	[]	Hepatitis A/B/C	[]	[]
PMS	[]	[]	HIV/AIDS	[]	[]
Other _____	[]	[]	Other _____	[]	[]

Do you have a history of cancer? [] Yes [] No

If yes, type of cancer _____ Location _____

Are you currently in treatment? [] Yes [] No

What treatments have you had in the past? _____

Consent for Care

It is my choice and I give my consent to receive massage therapy. I have reported all health conditions that I am aware of, and I will inform my therapist of any changes in my health information.

Signature _____ Date _____