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Massage Health Intake Form

Name:_____ DOB:____/_____/_____
Address:_____ City:_____ State:_____ Zip:_____
Phone:(___)_____Cell:(___)_____ Text: Y/N Best time contact:_____
Occupation:_____ Work Phone:(___)_____
Email:_____
How did you hear about me?/Who referred you?:_____

Please answer "Yes" or "No" to the following questions and provide any necessary clarifications.

Yes / No Have you ever had a massage before? If "Yes", Date of last massage: ____
Yes / No Are you currently under the care of a physician or other health care provider for a specific medical condition? If "Yes", please describe;
_____
Yes / No Are you taking any medication (including aspirin, Ibuprofen) If "Yes", please list what they are for:_____
Yes / No Any health problems or conditions? _____

Please circle any items or conditions that apply to you. Please explain any items you circle.

Cancer Pregnancy Sleeping Disorders Depression Diabetes Surgeries

Arthritis Headaches Heart Concerns Asthma Fibromyalgia Other:
_____
_____

Would you prefer to have a full body massage or just focus on specific areas? _____
Areas of injury, or areas you would like focused on?: _____
Things you like or dislike during a massage?:_____

I understand that massage is a form of relaxation/treatment but does not substitute a doctor's treatment or diagnosis. Any suggestions made by my therapist are only suggestions and I should consult with a doctor before trying. I also understand that any side effects and complications that might come as a result of my massage is taken at my own risk and my massage therapist will not be held accountable. I have stated all my known medical conditions and take it upon myself to keep my massage therapist updated on my physical health, doctors findings, & prescriptions.

Signature:_____ Date: _____