Massage Client Intake Form

Please type or print legibly

Name: _____ Email: _____

Address: _____ City/State/Zip: _____

Phone: (H) _____ (W) _____ (C) _____ Birthday: ____/____/____

Occupation: _____ Referrred to This Office By: _____

General and Medical Information

Y N Have your ever had a professional massage? If yes, how often? _____ _____

What kind of massage do you like? Gentle _____ Relaxing _____ Deep _____

Y N Are you pregnant? If yes, how many months? _____

Y N Are you sensitive to touch/pressure in any area (ticklish)? _____

Y N Do you have any allergies? What kinds? To what? _____

_____

List any current medications and reason _____

_____

_____

List recent surgeries (less than 6 months) _____

_____

_____

Indicate Areas of Pain/Tension:

On a scale of 1 to 10 (highest), rate your level of:

Stress: _____ Pain: _____ Energy: _____

On the other side of this page is a body chart, please circle the areas you have pain or discomfort.

How did your symptoms begin and when did it start?

_____

_____

What have you done for relief?

_____

_____

Is it getting better or worse?

_____

_____