

Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? yes no

If yes, please list name and use: _____

Are you currently pregnant? yes no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? yes no

If yes, please explain _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? yes no

If yes, please list: _____

Please indicate any of the following that apply to you.

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Sprains or Strains |

Explain any conditions you have marked above:

Massage Information

Have you had a professional massage before? yes no

What type of massage are you seeking?

- Relaxation Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

- Light Medium Deep

Do you have any allergies or sensitivities? yes no

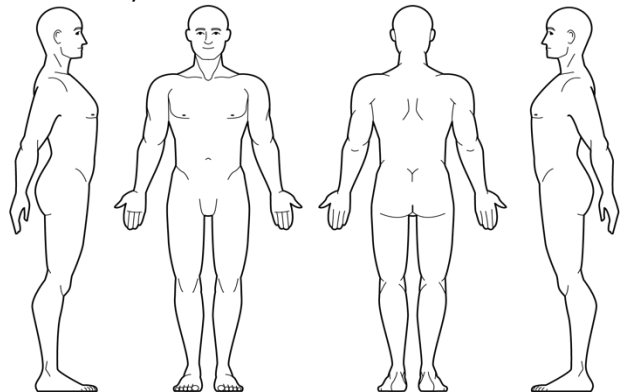
Please explain _____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? yes no

Please explain _____

What are your goals for this treatment session?

Please circle any areas of discomfort



*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
changes at any time.*

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Would you be interested in having a FREE Body Sculpting Consultation about CoolSculpting or Skin Tightening? Yes / No