

NEW CLIENT INTAKE FORM

MASSAGE THERAPY SERVICES

PERSONAL INFORMATION

Name _____ Phone _____ Email _____
Address _____ City/State/Zip _____ DOB _____
Emergency Contact _____ Relationship _____ Phone _____
How Did You Hear About Us? _____

MEDICAL INFORMATION

Are you taking any medications? Yes No
If yes, please list: _____

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? _____

Do you currently have any injuries? Yes No
If yes, please explain _____

Please indicate any of these conditions 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 |

MASSAGE INFORMATION

Have you had a professional massage before? Yes No

What type of massage are you seeking?
 Relaxation Therapeutic/Deep Tissue

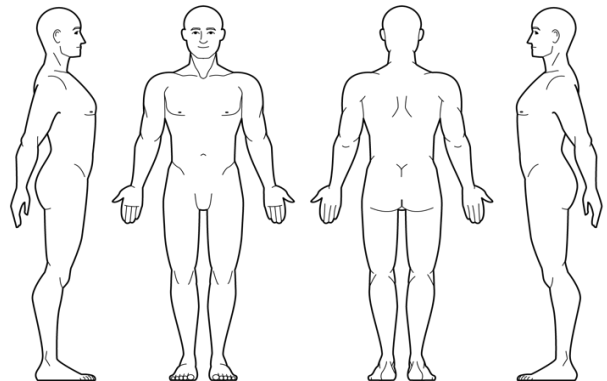
Other _____

What pressure do you prefer?
 Light Medium Deep

Do you have any allergies or sensitivities? Yes No
Please explain _____

Are there any areas you don't want massaged? Yes No

Please circle any areas of discomfort or tenderness:



Please explain any conditions or areas of discomfort you have marked above: _____

I have completed this form to the best of my ability, and I agree to inform my therapist if any of the above information changes:

Print Name _____ **Signature** _____ **Date** _____