



INTAKE FORM

PAGE 1 OF 2

First Name _____

Date of birth _____

Last Name _____

Referred by _____

Email Address _____

Mobile Phone # _____

Home Phone # _____

Work Phone # _____

Street Address _____

City _____

State _____

Zip Code _____

Emergency contact name _____

Physician's name _____

Emergency contact relationship _____

Physician's phone # _____

Emergency phone # _____

Date of initial visit _____

How would you rate your general
health?

☐ Excellent

☐ Good

☐ Fair

☐ Poor

Have you had a professional massage before?

☐ Yes (*Date of last treatment*)

☐ No

List current medications & the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or
hypersensitivities

Reason for initial visit



HEAD NECK

- ☐ Headaches / migraines
- ☐ Ringing in ears
- ☐ Vision problems
- ☐ Vertigo / dizziness
- ☐ Hearing loss
- ☐ Vision loss

RESPIRATORY

- ☐ Asthma
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Frequent colds
- ☐ Family history of respiratory difficulties
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Sinusitis
- ☐ Smoker

NERVOUS SYSTEM

- ☐ Sensory loss / change
- ☐ Sciatica
- ☐ Seizures
- ☐ Numbness / tingling
- ☐ Epilepsy
- ☐ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ☐ Arthritis
- ☐ Family history of arthritis
- ☐ Bursitis
- ☐ Pins / plates / wires / artificial joint
- ☐ Tendonitis
- ☐ Osteoporosis
- ☐ Jaw pain (TMJ)

REPRODUCTIVE

- ☐ Pregnant
- ☐ Gynecological problems
- ☐ Given birth

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart disease
- ☐ Phlebitis / varicose veins
- ☐ Hemophilia
- ☐ Chronic congestive heart failure
- ☐ Family history of cardiovascular problems
- ☐ Low blood pressure
- ☐ Stroke
- ☐ Poor circulation
- ☐ Pacemaker

SKIN & INFECTIONS

- ☐ Hepatitis
- ☐ Herpes
- ☐ Lyme disease
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Infectious skin conditions

OTHER CONDITIONS

- ☐ Cancer
- ☐ Unexplained weight loss
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Psychiatric disorder
- ☐ Other conditions
- ☐ Diabetes
- ☐ Digestive conditions
- ☐ Chronic fatigue syndrome
- ☐ Anxiety

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature: _____ Date: _____