Massage Therapy Intake Form

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Best Phone Contact: _____ Other Phone (optional): _____

E-Mail: _____ Date of Birth: _____

Occupation: _____ Referred by: _____

First time receiving Massage? ☐ Yes, ☐ No

Primary reason for visit: _____
_____

Please note any Medications or Dietary Supplements you may be taking and why:
_____

Recent or Past injuries/Medical Conditions: _____
_____

Please check all that apply, and explain in space provided.

Allergies: Yes ☐ _____
Arthritis: Yes ☐ _____
Cancer: Yes ☐ _____
Chronic Back Pain: Yes ☐ _____
Diabetes/Hypoglycemia: Yes ☐ _____
Fever: Yes ☐ _____
Frequent Headaches: Yes ☐ _____
Seizures: Yes ☐ _____

Heart Problems: Yes ☐ _____
High Blood Pressure: Yes ☐ _____
Neck/Spine Injury: Yes ☐ _____
Phlebitis Yes ☐ _____
Pregnancy: Yes ☐ _____
Skin Disorders: Yes ☐ _____
Varicose Veins: Yes ☐ _____

Other: _____

Are you currently under the care of a health professional? ☐ Yes, ☐ No
Health Care Provider's Name: _____ Phone #: _____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is no substitute for medical examination. I take responsibility for informing my practitioner of any physical, mental, or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) will be charged full price for the missed session.

Signature: _____ Date: _____
Rates: $70/30mins, $100/60 mins, $150/1.5hrs, $200/2hrs