

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 <input type="checkbox"/> _____	Heart Problems: Yes <input type="checkbox"/> _____
Arthritis: Yes <input type="checkbox"/> _____	High Blood Pressure: Yes <input type="checkbox"/> _____
Cancer: Yes <input type="checkbox"/> _____	Neck/Spine Injury: Yes <input type="checkbox"/> _____
Chronic Back Pain: Yes <input type="checkbox"/> _____	Phlebitis Yes <input type="checkbox"/> _____
Diabetes/Hypoglycemia: Yes <input type="checkbox"/> _____	Pregnancy: Yes <input type="checkbox"/> _____
Fever: Yes <input type="checkbox"/> _____	Skin Disorders: Yes <input type="checkbox"/> _____
Frequent Headaches: Yes <input type="checkbox"/> _____	Varicose Veins: Yes <input type="checkbox"/> _____
Seizures: Yes <input type="checkbox"/> _____	

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, \$120/hr, \$165/1.5hrs, \$215/2hrs