



## Massage Therapy Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email: \_\_\_\_\_ DOB: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred By: \_\_\_\_\_

Other Healthcare Practitioners: \_\_\_\_\_

Medications you now take: \_\_\_\_\_

Past falls or accidents: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Do you have any of the following conditions?

\_\_\_\_\_ Arthritis                      \_\_\_\_\_ Allergies (including oils and or/creams) \_\_\_\_\_

\_\_\_\_\_ Headaches                      \_\_\_\_\_ Chronic pain (where?) \_\_\_\_\_

\_\_\_\_\_ Pregnancy                      \_\_\_\_\_ Due Date: \_\_\_\_\_

\_\_\_\_\_ Varicose Veins                      \_\_\_\_\_ Flu or Cold                      \_\_\_\_\_ Fever

\_\_\_\_\_ Inflammation                      \_\_\_\_\_ Infection                      \_\_\_\_\_ Contagious disease

\_\_\_\_\_ Appliances (Screws, Pacemakers, etc...) \_\_\_\_\_

\_\_\_\_\_ Cancer                      \_\_\_\_\_ Diabetes                      \_\_\_\_\_ Epilepsy/Seizures

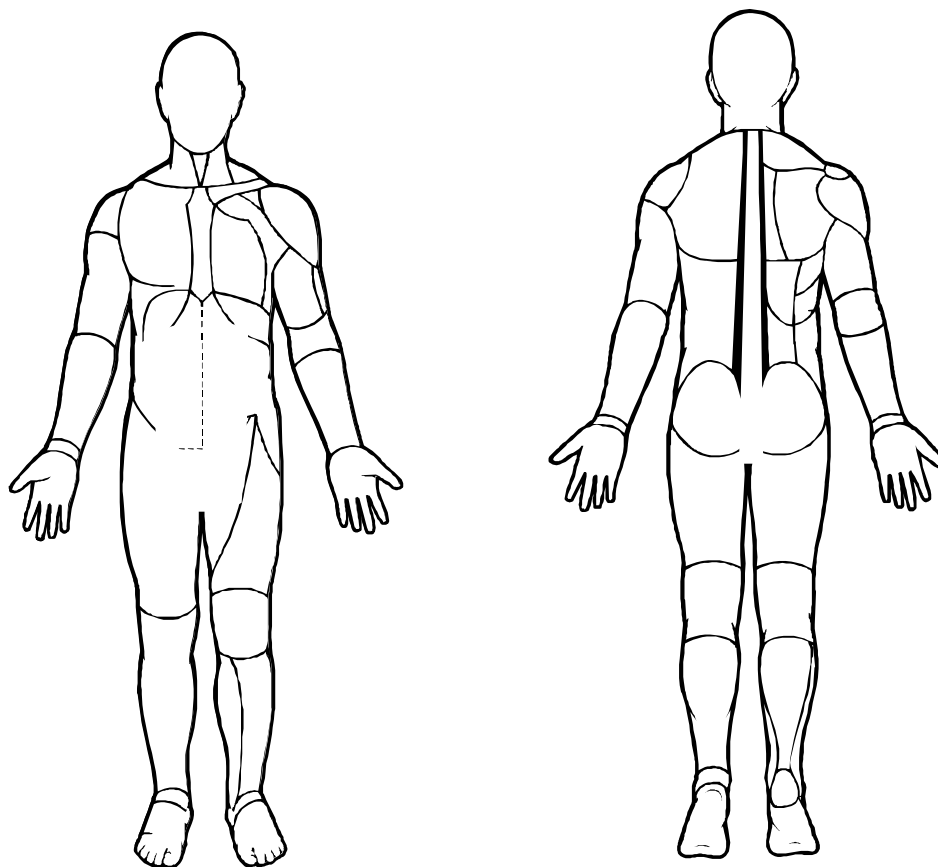
\_\_\_\_\_ High Blood Pressure                      \_\_\_\_\_ Low Blood Pressure                      \_\_\_\_\_ Skin Problems

\_\_\_\_\_ Muscle Spasms                      \_\_\_\_\_ Stroke                      \_\_\_\_\_ Circulatory Problems

Other conditions you feel may affect your treatment: \_\_\_\_\_

\_\_\_\_\_ Pregnant                      \_\_\_\_\_ Due Date

\_\_\_\_\_ New Mother                      \_\_\_\_\_ Nursing



**Please indicate areas of pain or discomfort on the diagrams above.**

**\*\* Please Read\*\***

I understand that massage therapy is an aid to health but does not take the place of any care my Medical Doctor may recommend. I have given correct information regarding my health and am not aware of any reason for not having massage therapy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Lifestyle Section**

Do you exercise? \_\_\_\_\_Y \_\_\_\_\_N. If yes, describe your

routine\_\_\_\_\_

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Do you consume the following beverages? \_\_\_\_coffee \_\_\_\_colas

\_\_\_\_alcohol \_\_\_\_water

How would you describe your eating habits?

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What do you hope to achieve through Massage Therapy?

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