Massage and Stretch Therapy Intake Form

Name: ____________________________________ Date: ______ Referred By: __________________
Address: __________________________________ Phone – Day: ______________________________
City/State/Zip: _____________________________ Phone – Eve: ______________________________
Birthday: __________________________________ Occupation/Employer: _______________________
Email Address: _____________________________

Massage and Stretch History

Have you ever received a professional massage? ___Yes ___No If yes, frequency: _________ Last Massage ________
What results do you want from your massage sessions? ____

Desired Pressure: Light ________ Firm ________ Deep ________
Prioritize the areas of your body that you would prefer to be massaged. ________________________________
Please check the areas of your body that you give permission to receive massage:
□ Back □ Legs □ Buttocks □ Arms □ abdomen □ Pecs/chest □ Neck □ Head □ face □ ________
List stress reduction and exercise activities. Include frequency. _____________________________________
How often do you stretch? ___________ Areas you feel are tightest in your body: ________________________

Medical History

Please list any recent injuries, illnesses, or surgeries: ____

Are you currently under the care of a physician? Yes________ No________
If yes, please explain. ____
List current medications, including aspirin, ibuprofen, etc. ______________________________________

Please check all that apply

____	Cancer: Type _____	____	Hi/Low Blood Pressure	____	TMJ
____	Migraines/Headaches	____	Immovable Joints	____	Tendonitis
____	Back Problems	____	Cold Hands/Feet	____	Bruise Easily
____	Sciatica	____	Sinus Problems	____	Allergies
____	Osteoporosis	____	Neck Problems	____	Fibromyalgia
____	Diabetes	____	Arthritis/Bursitis	____	Carpal Tunnel

Do you have any chronic or frequent pain? ____
Are you pregnant? _____ If yes, how far along are you? ____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the proper health care providers of my condition. I understand that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. If, for any reason cancellation is necessary, I will give a 24-hour notice. I understand that if I do not give this notice, I will be charged for the appointment unless it can be filled. Emergency cancellations will be determined by my therapist.

_________________________________ _________________________________
Signature Date