Intake Form

Personal Information:

Name: ______________________________________ Phone: _____________________ DOB: ___________

Address: ____

Email: ____ Occupation: _____________________________

Emergency Contact (Name): __________________________ Relationship: _________ Phone: ____________

Medical Information:

Are you currently taking any medications? __________

If yes, please list: ____

Are you currently pregnant? ________

If yes, how far along? ____

If yes, are there any high-risk factors? ____

Any recent injuries or surgeries (within 2 years OR affects your current pain patterns)? _____________

If yes, please explain: ____

____

Have you experienced any of the following? Please circle all that apply:

Fibromyalgia	Arthritis	Diabetes
Cancer	Heart Attack	Blood clots
Headaches/Migraines	Kidney Dysfunction	High/Low Blood Pressure
Stroke	Neuropathy	Allergies
Depression/Anxiety	PTSD	Narcolepsy

Please explain: ____

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Massage Information:

Have you received professional massage before? Yes____ No_____

Are there any areas you would like the therapist to focus on? ____

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Are there any areas you would like the therapist to avoid (i.e. glutes, face, feet)? __________________________

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Client Signature:____ *Date:*_____________________