

Message Intake Form - CONFIDENTIAL INFORMATION

Name _____ Date of birth _____

Address _____

State _____ City _____ Home Phone _____

Work Phone _____ Occupation _____

Have you ever received massage therapy? _____ Yes _____ No

Type of massage experienced (swedish, shiatsu, deep tissue, etc.) _____

Are you currently taking any medications? _____ Yes _____ No

If yes, please list name and reason for medications _____

Are you currently seeing a healthcare professional? _____ Yes _____ No

If yes, please list names and reason/treatment _____

Please review this list and check those conditions that have affected your health either recently or in the past.

- | | |
|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> depression, panic disorder, other psych condition |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> diverticulitis |
| <input type="checkbox"/> blood clots | <input type="checkbox"/> headaches |
| <input type="checkbox"/> broken/dislocated bones | <input type="checkbox"/> heart conditions |
| <input type="checkbox"/> bruise easily | <input type="checkbox"/> back problems |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> chronic pain | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> constipation/diarrhea | <input type="checkbox"/> muscle strain/sprain |
| <input type="checkbox"/> auto-immune condition* | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> hepatitis (A, B, C, other) | <input type="checkbox"/> scoliosis |
| <input type="checkbox"/> skin conditions | <input type="checkbox"/> seizures |
| <input type="checkbox"/> stroke | <input type="checkbox"/> whiplash |
| <input type="checkbox"/> surgery | <input type="checkbox"/> chemical dependency (alcohol, drugs) |
| <input type="checkbox"/> TMJ disorder | |

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so: _____

Do you have any of the following today:

_____ skin rash _____ cold/flu _____ open cuts _____ severe pain
_____ anything contagious _____ injuries/bruises

Do you have any allergies to:

_____ medications _____ foods (nuts, etc.)
_____ environmental allergens (dust, pollen, fragrances)
_____ reactions to skin care products

If any of the above are checked, please give details: _____

What results would you like to see from your sessions?

Please read the following information and sign below:

All massage received will be therapeutic wellness massage, to promote relaxation and relieve discomfort caused by tension. By signing I declare that, to the best of my knowledge, the above information is accurate and truthful. According to informed consent, I acknowledge that I am aware of the minor potential for soreness, bruising, or headaches in the days following a therapeutic massage. I also acknowledge that I am aware that any massage received will be non-sexual in nature. If, at any time, either client or therapist feels uncomfortable with the situation, the session may be terminated immediately.

Signature: _____ Date _____