# Massage Intake Form

Name:_____ Phone# : (____)_____-_____D.O.B:____/____/_____

Address:_____ City_____ State:_____ Zip:_____

Email:_____ Referred By:_____

In Case of Emergency:_____ Phone#(_____)_____-_____

Occupation:_____ Physician:_____

Have you ever experienced a professional Massage or Bodywork Session? Yes No

What pressure do you prefer? Light Medium Firm

| | | |
|---|---|---|
| Do you experience frequent headaches? | Yes | No |
| Do you sit at a computer a lot in your occupation | Yes | No |
| Are you pregnant? | Yes | No |
| Are you diabetic? | Yes | No |
| Do you have high blood pressure? | Yes | No |
| Do you suffer from joint problems swelling/stiffness-arthritis, sacroiliac problems, other_____ | Yes | No |
| Do you have any skin conditions, rash, hives, skin cancer, other_____ | Yes | No |
| Do you have warts or fungal infections? | Yes | No |
| Do you suffer from lymphatic conditions-swollen gland, nasal congestion, lymph edema | Yes | No |
| Do you have varicose veins/blood clots? | Yes | No |
| Do you bruise easily? | Yes | No |
| Have you had a recent injury or accident-whiplash, sprain, bruise, other_____ | Yes | No |
| Any broken bones/injuries in the last two years? Specify_____ | Yes | No |
| Do you have bone conditions-osteoporosis, fracture, other_____ | Yes | No |
| Do you have cardiac or circulatory problems? | Yes | No |
| Do you have numbness or stabbing pain? | Yes | No |
| Are you sensitive to touch/pressure in any area? | Yes | No |
| Are you allergic or sensitive to any oils (Essential Oils, Nut oils, scents)? If yes please list:_____ _____ | Yes | No |

Have you had surgery in the last two years?
Specify:_____

Are you taking any medications or have other medical/health conditions_____

_____

On a scale from 1-10, 10 = highest, rate your levels of: Stress_____ Pain_____

Signature_____ Date_____