

## Massage Intake Form

Welcome! I would like to make your appointment as pleasant and comfortable as possible.  
If at any time, you have questions regarding your session, please let me know.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ City: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Have You Ever Received Massage Therapy? YES NO (Circle One) IF Yes, What Type? \_\_\_\_\_

Are you currently taking any medications? If yes, please list name and reason for each one: \_\_\_\_\_

Are you currently seeing a healthcare professional? 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. Place a check mark next to EACH condition:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Blood Clots      | <input type="checkbox"/> Broken/Dislocated Bones   |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Chronic Pain     | <input type="checkbox"/> Constipation/Diarrhea     |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Surgery        | <input type="checkbox"/> TMJ              | <input type="checkbox"/> Skin Conditions           |
| <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Whiplash         | <input type="checkbox"/> Auto-Immune Disease       |
| <input type="checkbox"/> Drugs/Alcohol | <input type="checkbox"/> Scoliosis      | <input type="checkbox"/> Pregnancy        | <input type="checkbox"/> Depression/Panic Disorder |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Back Problems  | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Insomnia                  |
| <input type="checkbox"/> Muscle Strain | <input type="checkbox"/> Diverticulitis |   |  |

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

\_\_\_\_\_

\_\_\_\_\_

THANK YOU AND ENJOY YOUR FACIAL!