Massage Intake Form

SANTOSHA space

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____ ☐ Subscribe to Monthly Wellness Newsletter

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list: _____

_____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness/Tingling
☐ Sprains or Strains

Explain any conditions you have marked, and any not listed:

_____

_____

_____

_____

Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What is your reason for seeking massage? _____

_____

What pressure do you prefer? ☐ Light ☐Medium ☐Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain _____

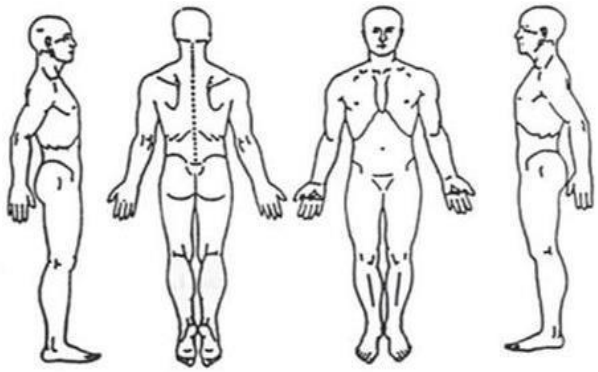
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



I understand that the massage/bodywork I receive is for the purposes of relaxation and relief of muscular tension, and is not considered a substitute for medical examination, diagnosis or treatment, and that nothing said during the course of treatment should be construed as such. Because massage should not be performed under certain medical conditions, I have stated all my known medical conditions, and will notify my therapist any time my condition changes.

Client Signature _____ *Date* _____