NEW CLIENT INTAKE FORM
MASSAGE THERAPY SERVICES

PERSONAL INFORMATION

Name _____ Phone _____ Email _____

Address _____ City/State/Zip _____ DOB _____

Emergency Contact _____ Relationship _____ Phone _____

How Did You Hear About Us? _____

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? _____

_____

Do you currently have any injuries? ☐ Yes ☐ No

If yes, please explain _____

Please indicate any of these conditions 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
- ☐ Sprains or Strains

MASSAGE INFORMATION

Have you had a professional massage before? ☐ Yes ☐ No

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

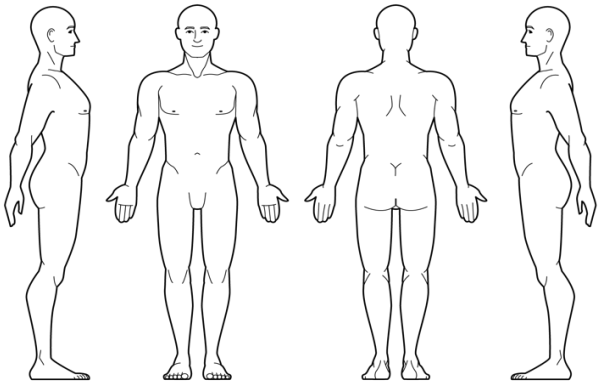
Do you have any allergies or sensitivities? ☐ Yes ☐ No

Please explain _____

Are there any areas you don't want massaged? ☐ Yes ☐ No

FACE/SCALP HANDS/FEET GLUTES ABDOMINAL

Please circle any areas of discomfort or tenderness:



Please explain any conditions or areas of discomfort you have marked above: _____

_____

_____

I have completed this form to the best of my ability, and I agree to inform my therapist if any of the above information changes:

Print Name _____ **Signature** _____ **Date** _____