

Therapist Name \_\_\_\_\_

Date \_\_\_\_\_

### **Massage Intake Form**

Name \_\_\_\_\_ DOB \_\_\_\_\_ M/F

Address \_\_\_\_\_

Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency

Contact \_\_\_\_\_ Phone \_\_\_\_\_

Please list all current or past injuries or medical conditions, incl. surgeries \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any medication/supplements? \_\_\_\_\_

\_\_\_\_\_

Are you currently under medical treatment? Yes/No

If so, what condition \_\_\_\_\_

Are you allergic to any type of oil/essential oils? Yes/No Which ones? \_\_\_\_\_

\_\_\_\_\_

#### **Health Issues (even minor ones)- Please tick if applicable:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bleeding Disorder         | <input type="checkbox"/> Brittle Bones              | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Flu/Fever                 | <input type="checkbox"/> Sciatica                   | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Infection                 | <input type="checkbox"/> Numbness                   | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> Deep vein thrombosis      | <input type="checkbox"/> Respiratory / Lungs        | <input type="checkbox"/> Jaw problems            |
| <input type="checkbox"/> Blood Clotting Disorder   | <input type="checkbox"/> Cancer / tumour            | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Skin infection / problems | <input type="checkbox"/> Headaches / migraine       | <input type="checkbox"/> Pregnancy               |
| <input type="checkbox"/> Acute Inflammation        | <input type="checkbox"/> Hernia                     | <input type="checkbox"/> Different long legs     |
| <input type="checkbox"/> Heart Conditions          | <input type="checkbox"/> Varicose veins / phlebitis | <input type="checkbox"/> Scoliosis               |
| <input type="checkbox"/> Joint / spinal Problems   | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Kyphosis (rounded back) |

Is there anything else about your health history that you think would be useful for me to know? \_\_\_\_\_

What kind of sports/exercise do you do? \_\_\_\_\_

What would you like to achieve from your massage session?

Pain reduction  Relaxation  Both  Other \_\_\_\_\_

I understand that the massage therapy I receive is for the purpose of relief from muscular tension, spasm or pain and stress reduction. If I experience any pain or discomfort during this session, I will immediately tell my therapist so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that massage therapists are not qualified to diagnose any illness or disease, and nothing said or done during the session should be construed as such. I further acknowledge that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment that I am aware of.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep my therapist updated as to any changes in my medical profile and understand that there shall be no liability on their part should I fail to do so.

It is common to have some pain and even slight swelling **for one or two days** after receiving deep corrective massage. This is called therapeutic inflammation.

Understanding all this, I give my consent to receive care.

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**Signature**

**Date**

**Please mark your areas of pain / stiffness:**

