Massage Intake Form

Personal information			
First name:		**Last name:**	
Date of birth:		**Gender:**	
Address:	**City:**	**State:**	**Zip code:**
Contact number:		**Email:**	

Emergency contact		
Full name:	**Relationship:**	**Contact number:**
Full name:	**Relationship:**	**Contact number:**

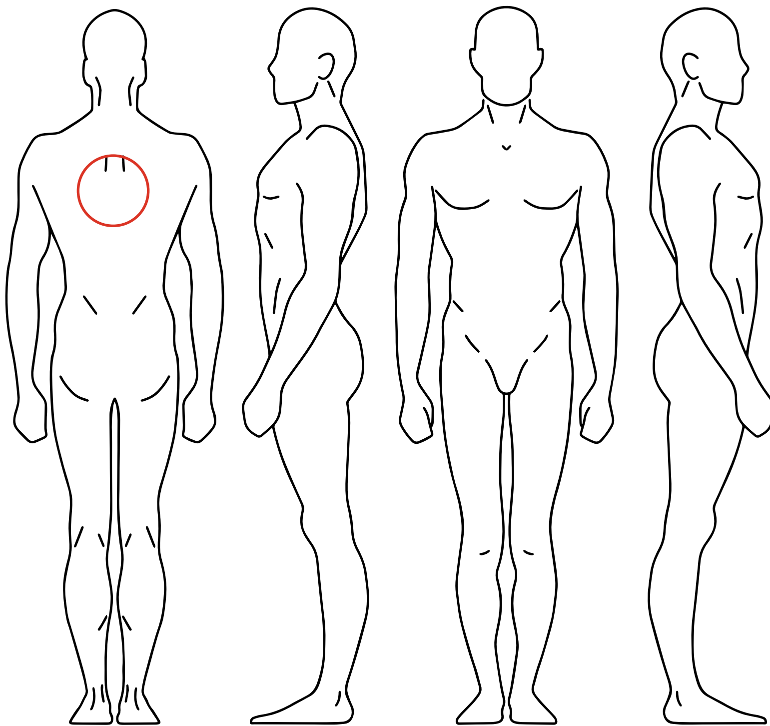
Medical information		
Please list any medical conditions or health problems you have had in the past or present:		
Are you taking any medications?	**Do you suffer from chronic pain?**	**Have you had any orthopedic injuries?**
Yes No	Yes No	Yes No
If yes, please specify:	If yes, please explain (including what makes it better or worse):	If yes, please list:

Massage information	
Have you had a professional massage before?	**What type of massage are you seeking?**
Yes No	Relaxation Therapeutic/Deep tissue Other:

Do you have any allergies or sensitivities?	Are there any areas (feet, face, abdomen, etc.) that you do not want to be massaged?
Yes No	Yes No
If yes, please explain:	If yes, please explain:

What are your goals for this treatment session?

Please indicate or describe any area of discomfort:



- Adhesion
- Rotation
- Pain
- Tender joint
- Hypertonicity
- Spasm
- Inflammation
- Trigger point
- Elevation

Insurance information	
Insurance carrier:	**Insurance plan:**
Contact number:	**Policy number:**
Group number:	**Social security number:**

Authorization	
By signing below, you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information change at any time.	
mjosh	
Client name and signature	**Date**
JBLUE	
Therapist name and signature	**Date**