Massage Therapy Client Intake Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Emergency Contact Name

Emergency Contact Phone

Health Information

Are you currently under a physician's care?

- Yes
- No

If yes, for what reason?

List any medications you are currently taking

Allergies (including skin sensitivity)

Medical Conditions / Surgeries

Are you pregnant?

- ○ Yes
- ○ No

Reason for Visit

What is the primary reason for your visit?

Areas of tension, pain, or discomfort

Preferred Pressure

Contraindications

Check any conditions that apply:

- ☐ Fever
- ☐ Recent Injury
- ☐ Infection
- ☐ Inflammation
- ☐ Blood Clots

Other (please specify):

Massage History

Have you received professional massage before?

- ○ Yes
- ○ No

Preferences, likes/dislikes

Additional Information

What are your goals for today's session?

Notes