Massage Therapy Intake Form

Personal Information

First Name

Last Name

Date of Birth

Phone Number

Email Address

Address

City

State/Province

Zip/Postal Code

Emergency Contact Name

Emergency Contact Phone

Health Information

Are you currently under a physicianâ€™s care?

If yes, please explain

Current Medications

Allergies

Do you have any chronic conditions or injuries?

What areas would you like to focus on during your massage?

Any areas you prefer to avoid?

Previous Massage Experience

Comments or Additional Information

Consent

I acknowledge that the information provided is accurate and complete to the best of my knowledge.

Signature

Date