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Massage Therapy Intake Form

Last Name: _____ First Name: _____ MI: _____

SS # _____ Date of Birth: _____Phone # _____

Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Is this your first professional massage? _____ If not, how often do you get treated? _____

What do you hope to accomplish from this session? _____

Are you aware of any areas of tension in your body? _____

Please list any past surgeries, hospitalizations, accidents, or injuries. Include dates.

_____

_____

Do you have any chronic, ongoing pain? If so, please explain.

_____

_____

What makes the problem better? _____ Worse? _____

Current Fam. Physician: _____ Last exam: _____

Current Chiropractor:_____ Last visit: _____

Please list any medications/supplements you are currently taking:

_____

Have you been or are you currently sick? _____

Any other health concerns you wish to discuss? _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____