

# Massage Intake Form

## Personal Information

Name \_\_\_\_\_ Phone (day) \_\_\_\_\_ (evening) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ DOB \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Email \_\_\_\_\_ Primary Physician \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## Medical Information

Are you taking any medications?  yes  no  
If yes, please list name and use: \_\_\_\_\_  
\_\_\_\_\_

Are you currently pregnant?  yes  no  
If yes, how far along? \_\_\_\_\_  
Any high risk factors? \_\_\_\_\_

Do you suffer from chronic pain?  yes  no  
If yes, please explain \_\_\_\_\_  
What makes it better? \_\_\_\_\_  
\_\_\_\_\_  
What makes it worse? \_\_\_\_\_  
\_\_\_\_\_

Have you had any orthopedic injuries?  yes  no  
If yes, please list: \_\_\_\_\_

Please indicate any of the following that apply to you.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |

Explain any conditions you have marked above:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Massage Information

Have you had a professional massage before?  yes  no

What type of massage are you seeking?  
 Relaxation  Therapeutic/Deep Tissue

Other \_\_\_\_\_

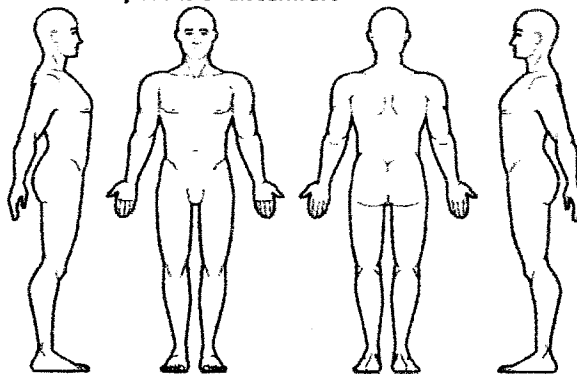
What pressure do you prefer?  
 Light  Medium  Deep

Do you have any allergies or sensitivities?  yes  no  
Please explain \_\_\_\_\_

Are there any areas (feet, face, abdomen, etc.) you do not want massaged?  yes  no  
Please explain \_\_\_\_\_

What are your goals for this treatment session?  
\_\_\_\_\_

Please circle any areas of discomfort



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  
changes at any time.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

## General Liability Release Form

By signing below, you agree to the following:

- 1) I give my permission to receive massage therapy.
- 2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.
- 3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.
- 4) I have clearance from my physician to receive massage therapy.
- 5) I understand the risks associated with massage therapy include, but are not limited to:
  - Superficial bruising
  - Short-term muscle soreness
  - Exacerbation of undiscovered injury

I therefore release the company and the individual massage therapist from all liability concerning these injuries that may occur during the massage session.

- 6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.
- 7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.
- 8) I understand that I or the massage therapist may terminate the session at any time.
- 9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

\_\_\_\_\_  
Client Print Name

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

# Health Information–COVID-19 Information & Liability Waiver

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

## COVID-19 Information

1. Have you had a fever in the last 24 hours of 100°F or above? Yes  No
2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes  No
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes  No

## Consent for Treatment

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature (in case of a minor): \_\_\_\_\_ Date: \_\_\_\_\_

