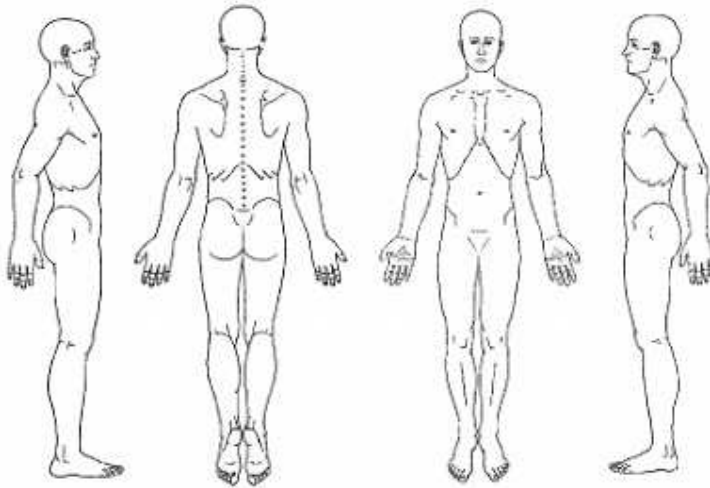


## Massage Intake Form

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

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

Circle any areas you would like me to focus on and place an X on any areas you would like me to avoid.



What are your top priorities for your service today?

\_\_\_\_\_

Please check any of the following that pertain to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Varicose Veins                | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Heart Problems                | <input type="checkbox"/> Blood Thinners       |
| <input type="checkbox"/> Wear Contacts | <input type="checkbox"/> Allergies to oils or perfumes | <input type="checkbox"/> Pregnancy            |
| <input type="checkbox"/> Inflammation  | <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Open cuts or bruises |

Any other health issues that we should be aware of? \_\_\_\_\_

We offer massage for all stages of pregnancy and postpartum, but it is the client's responsibility to seek doctor's approval, as with receiving massage with any medial condition. \_\_\_\_\_ (please initial)

In case of emergency, please notify: \_\_\_\_\_ Phone: \_\_\_\_\_

The above information is correct to the best of my knowledge. I agree that I am responsible for any damages or injuries resulting from my failure to provide accurate information. I also understand that massage is not a replacement for medical care and that no diagnosis will be made.

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