



chart form : massage therapy intake form

DATE: _____

NAME: _____ D.O.B _____ AGE _____

MAILING ADDRESS (inc zip) _____

EMAIL: _____ ADD TO MY NEWSLETTER? YES / NO REF BY: _____

PH #'s: HOME(____) _____ CELL(____) _____ WORK(____) _____

OCCUPATION: _____ Have you received massage therapy before? YES / NO

Type of massage experienced: Deep / Swedish / Other When was your last session? _____

Are you pregnant? Yes / No Have you consumed alcohol in the last 24 hours? Yes / No

Are you under the care of any medical, naturopathic or chiropractic physician? _____

If so, are you receiving treatment? And what is the working diagnosis? _____

Do you receive care from any other health professional? What and how frequently? _____

List any current medications: _____

How much water did you drink in the past 24 hours? _____ Is this a normal for you? _____

On the list below, underline any you have had in the past week AND circle any you have daily:
 coffee other caffeine alcohol soda sugar tobacco salt animal products grains fried foods fast food

Sleep well? YES / NO How many hours nightly? _____ Exercise? YES / NO What type / How often? _____

How do you feel today? _____

Is there any condition that concerns you (if not already addressed)? _____

On the list below circle any thing that might currently apply to you:
 sunburn inflammation severe pain headache open cuts bruises burns rash poison ivy cold flu

Do you have a history of any of the following (please circle):
 Accident / neck pain / whiplash / headaches / shoulder pain / upper back pain / mid back pain / lower back pain / joint ache / decreased range of motion / broken bones / sciatica / sprains / seizures / abdominal pain / nervous tension / arthritis, bursitis, or gout / allergies to oils or perfumes / wear contacts / scoliosis / surgery / fibromyalgia / carpal tunnel syndrome / mastectomy / breast augmentation / diabetes / varicose veins / high blood pressure / stroke / heart attack / cancer / colitis / HIV / _____?

Please read and sign below:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

Signature of Client

Date of Signature

Signature of Therapist

Date of Signature