Massage Intake Form

Last Name ___________________________      First Name ___________________________    University ID Number _______________________________

Have you ever had a professional massage? ________________________________
If so, when was your last massage? __________________________________________
How frequently did you get massages? _________________________________________
Preferred types of massage? ________________________________________________
Reasons for seeking massage? ______________________________________________
Do you have special needs I should prepare for? ________________________________

Do you have any of the following conditions? Check all that apply.

- Accident or suffered any injuries in the past two years:
- Allergies to essential oils and/or lotion ingredients:
- Arthritis (rheumatoid, osteoarthritis)
- Blood clots
- Broken bones:
- Bruise easily
- Cancer
- Cardiac or circulatory problems
- Contagious disease:
- Diabetes
- Digestive conditions (e.g. Crohn’s, IBS)
- Depression, anxiety
- Endocrine, thyroid conditions
- Epilepsy or seizures
- Gas, bloating, constipation
- Headaches, Migraines
- High/Low Blood Pressure
- Muscle or joint pain/stiffness
- Osteoporosis, degenerative spine/disk
- Pregnant
- Sensitive to touch/pressure
- Shortness of breath, asthma
- Skin disorder:
- Stroke, heart attack
- Surgery in the past 5 years
- Varicose veins
- Other Medical Conditions: ________________________________

Would you like us to concentrate in any specific areas? You can indicate on the image or describe below.

Client Signature ___________________________    Date ___________________________