Massage Therapy Intake Form

Nicco Castell LMT

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PERSONAL INFORMATION

Name _____ Date Of Birth _____

Address _____

City _____ State _____ Zip Code _____

E-Mail _____ Phone _____

Emergency Contact _____ Phone _____

MEDICAL INFORMATION

Are you taking any medication? ☐ Yes ☐ No

If yes, please describe _____

Do you suffer from chronic pain? ☐ Yes ☐ No

If yes, please describe _____

Have you had any orthopedic injuries? ☐ Yes ☐ No

If yes, please describe _____

Please indicate any of the following that apply to you:

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ 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

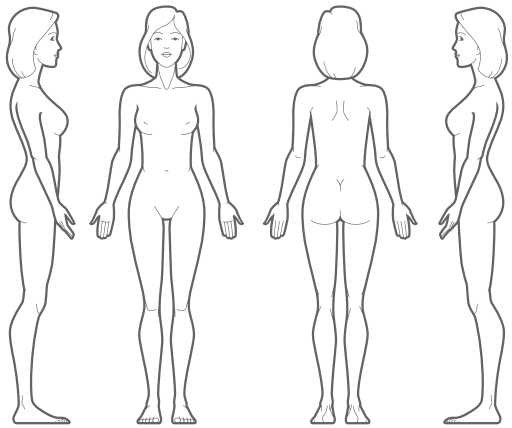
What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivites? ☐ Yes ☐ No

If yes, please describe _____

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 _____