# Massage Intake Form

## Personal Information

Name Bella Milla Phone (day) 0409525755 (evening) _____

Address 559 Byala Lane City/State/Zip _____ DOB _____

Occupation NAS Employer _____

Email Bella.Milla201295@icloud.com Primary Physician _____

Emergency Contact Dean Relationship _____ Phone 0477215914

How did you hear about us? walking past

## 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.

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

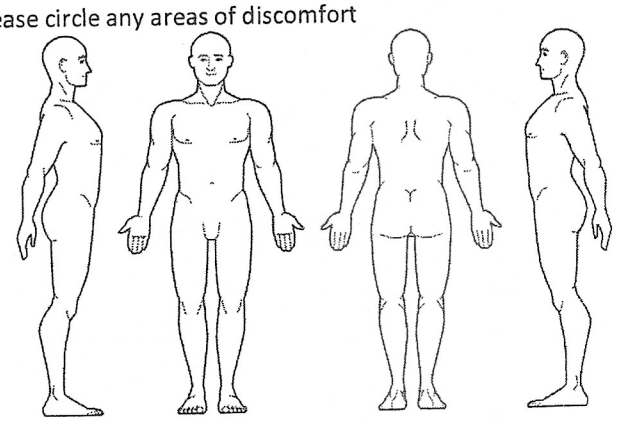
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

Please explain _____

What are your goals for this treatment session?

Relaxation

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* Bella *Date* 4/23

*Therapist Signature* _____ *Date* _____