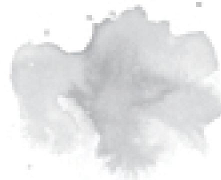

MASSAGENVY

Massage Therapy Client Intake Form

Name ______________________________ Date ________________________

Birthdate ___________________________ Address

____ City ________________

Postal Code ____________________ Email ____________________________

Occupation ____________________________

Emergency Contact____________________ Phone ________________

Physician ____________________________ Phone ___________________

Currently on any medications_______________________________________

Circle any that apply

Allergies Arthritis Blood Clots Blood Pressure High/Low

Bruise Easily Carpal Tunnel CancerDiabetes

Fibromyalgia Heart Condition Insomnia Inflammation

Kidney Disorder Numbness Parkinson Scoliosis Sciatica

Stroke TMJ Problems

Is this treatment for a motor vehicle accident? Yes/No

Are you pregnant? Yes/ No If yes how far along are you?

Identify any painful areas on these drawings using an X