Therapia
WELLNESS CLINIC

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Massage Therapy Intake Form

General Information

Legal Name:_____ What name do you use (if different)?_____

Assigned Sex: M F I Gender Identity:_____ Pronoun:_____ Date of Birth:____/____/____

Address:_____ City:_____ State:_____ Zip:_____

Phone:(_____) _____-_____ Email:_____

Emergency Contact:_____ Relationship:_____ Phone:(_____) _____-_____

Occupation:_____ How did you hear about us? _____

Have you ever experienced a professional massage or bodywork session? No Yes How recently? _____

Medical Information

Yes	No		Yes	No	
☐	☐	Do you frequently suffer from stress?	☐	☐	Do you have diabetes?
☐	☐	Do you experience frequent headaches?	☐	☐	Do you have arthritis?
☐	☐	Are you wearing contact lenses?	☐	☐	Do you have high blood pressure?
☐	☐	Are you wearing dentures?	☐	☐	Do you have epilepsy or seizures?
☐	☐	Are you pregnant? Number of births:_____	☐	☐	Do you have varicose veins?
☐	☐	Do you suffer from joint swelling?	☐	☐	Do you have osteoporosis?
☐	☐	Do you bruise easily?	☐	☐	Do you have cardiac or circulatory problems?
☐	☐	Have you broken any bones in the past 2 years?	☐	☐	Have you ever had surgery?
☐	☐	Do you suffer from back pain?	☐	☐	Do you have any contagious diseases?
☐	☐	Have you been in an accident or been injured in the past 2 years?	☐	☐	Do you experience numbness or stabbing pains? Where? _____
☐	☐	Do you experience tension/soreness? Where? _____			

Please list any known allergies: _____

Please explain any other medical conditions: _____

Please list any medications you are currently taking (medication/frequency/diagnosis): _____

_____

If you answered "yes" to any of the previous questions, please explain as clearly as possible: _____

_____

Please take a moment to carefully read the following information and sign where indicated:

I understand the massage/bodywork I receive is for the basic purpose of relaxation and relief of muscular tension. If I experience pain or discomfort during the session, I will inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I understand that, as with any treatment, there may be risks, including skin irritation from scented oils and temporary pain from prolonged positions/deep pressure. I have been given time to ask questions about massage treatment. I understand massage should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a qualified medical specialist for any mental or physical ailment of which I am aware. I understand massage practitioners are not qualified to perform spinal/skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

_____ _____

Patient/Guardian Signature Date