Massage Intake Form

227 N Spring St
Greensboro, NC 27401

Greensboro
MASSAGE AND BODYWORK

Name: _____ Phone: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____

Email: _____

Occupation: _____

Emergency Contact - Name: _____ Number: _____

Have you had a professional massage before? ☐ No ☐ Yes When? _____
What level **pressure** do you prefer: ☐ Light ☐ Medium ☐ Deep
Are you comfortable receiving therapeutic work on your:

☐ Face ☐ Scalp ☐ Glutes ☐ Pecs ☐ Feet

Circle any of the following **conditions** if they apply to you:

Back Pain	Allergies	Arthritis	Asthma
Cancer	Bruise Easily	Sciatic Pain	Contagious Disease
Headaches	Heart Disease	Joint Disease	Seizures/Epilepsy
Pregnancy	High Blood Pressure	Osteoporosis	Varicose Veins
Eczema	Lung Disease	Thyroid Disorder	Diabetes

Have you had any major **injuries**?_____

_____

Have you had any major **surgeries**? _____

_____

If you are currently taking any **medications**, please describe: _____

_____

I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorder. They do not prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. All massages here are for healthful purposes and will not include any sexual conduct. I have stated all medical conditions that I am aware of and will update the massage therapist of any changes in my health status.

Signature: _____ Date: _____