# MRVFC Massage Intake Form

Name _____ Phone (day) _____ (evening) _____

Address _____City/Province/Postal Code _____ DOB (m/d/y) _____

Occupation _____ Employer _____

Email _____ **Recreational Activities**:_____

Emergency Contact _____ Relationship_____ Phone _____

How did you hear about us? _____

## 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 surgeries? ☐ 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 | ☐ Blood Cloths | ☐ Kidney Dysfunction |
| ☐Numbness | ☐ Neuropathy | ☐ Joint Replacement(s) |
| ☐ Asthma | ☐ Depression | ☐ High Blood Pressure |
| ☐Fatigue | ☐ Tingling | ☐ Low Blood Pressure |
| ☐ Hernias | ☐ Skin Disorder | ☐ Sprains/Strains |
| ☐ Rashes | ☐ Varicose Veins | ☐ Vision Problems |

☐ Hearing Conditions ☐ Digestive Problems ☐Seizures

Explain any conditions you have marked above and any that are not listed:

_____

_____

_____

_____

## 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 _____

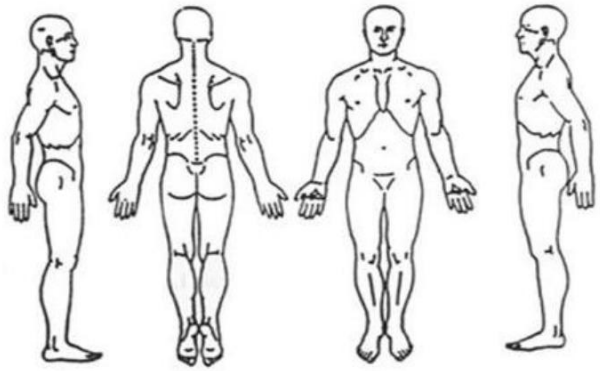
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

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. I release the massage therapist from any and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this client history. I understand that any cancelled appointment without 24 hours' notice is subject to a 50% charge.*

*Client Signature* _____ *Date* _____

*Therapist Signature* _____ *Date* _____