**Onsite massage intake form**

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| Name: | | | Date: | | Gender (M or F): |
| DOB: | Address: | | | | |
| Emergency contact (name and number): | | | | | |
| Contact numbers | | Home: | | Mobile: | |
| Reason for seeking massage: | | | | | |
| List typical daily activities (work, exercise, home): | | | | | |
| List all illnesses, injuries and health concerns you have now or have had in the past three years (e.g diabetes, arthritis, broken bones, pregnancy). | | | | | |
| List all medications and pain relief taken this week: | | | | | |
| Do you currently or frequently have any of the following (Y or N)? | | | | | |
| Lower back pain: | | Neck pain: | | Headaches: | |
| Do you have any other muscular, skeletal or connective tissue conditions? | | | | | |
| Are you currently experiencing any of the following (Y or N). If yes, please explain: | | | | | |
| Pain/tenderness: | | Numbness or tingling: | | Stiffness: | |
| Swelling: | | Allergies: | |  | |
|  | | | | | |
| I have provided all my known medical information. I acknowledge that massage therapy is not a substitute for medical diagnosis and treatment. I consent to receive treatment. | | | | | |
| Signature: | | | Date: | | |

Presenting Condition:

Treatment:

Signature: Date:

