Massage Intake Form

Personal Information

Name ________________________________ Phone (day) __________________ (evening) _______________

Address _______________________________ City/Sate/Zip ______________________ DOB ______________

Occupation ____________________________________ Employer ______________________________________

Email ____ Primary Physician ____________________________

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 orthopedic surgeries? ☐ yes ☐ no

If yes, please list: __________________________________

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

If yes, explain: _______________________________

____

Are there any areas (feet, face, abdomen,

etc.) you do not want massaged?

☐ yes ☐ no

Please explain: _______________________________

____

Milan Center
Chiropractic

Please indicate any history of the following that apply

☐ Cancer

☐ Headaches/Migraine

☐ Arthritis

☐ Diabetes

☐ Joint replacement(s)

☐ High/Low Blood Pressure

☐Neuropathy

☐ Fibromyalgia

☐ Stroke

☐ Heart Attack

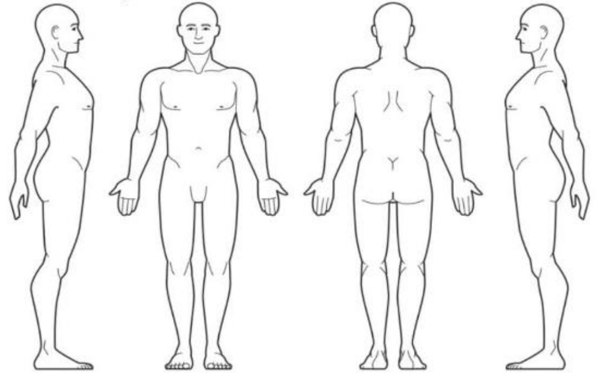
☐ Kidney Dysfunction

☐ Blood Clots

☐ Numbness

☐ Sprains or Strains

Please circle any areas of discomfort



Explain any conditions you have marked above:

____

____

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.

Client Signature ____ Date _______________________________

Therapist Signature ____ Date ___________________________