

MESSAGE INTAKE FORM

Business Name: _____

Date: _____

Comprehensive intake form for massage therapy clients. Collects health history, pain areas, pressure preferences, and treatment goals.

** Required fields*

Full Name *

Jane Doe

Email *

jane@email.com

Phone Number *

(555) 123-4567

Date of Birth *

Address

Emergency Contact Name *

Emergency Contact Phone *

Occupation

Helps identify postural patterns

How did you hear about us?

Options: Google / Referral / Insurance / Social Media / Walk-in / Other

Reason for visit *

Options: Pain relief / Stress/relaxation / Sports recovery / Injury rehabilitation / Prenatal massage / General wellness / Other

Areas of pain or tension

Neck, lower back, shoulders, etc.

Pain level (1-10)

Options: 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10

How long have you had this condition?

Options: Less than a week / 1-4 weeks / 1-3 months / 3+ months / Chronic/ongoing

Pressure preference *

Options: *Light / Medium / Firm / Deep tissue / No preference*

Medical conditions (check all that apply)

High/low blood pressure, diabetes, heart disease, cancer, blood clots, skin conditions, recent surgery...

Current medications

Are you pregnant? *

Options: *Yes / No / N/A*

If pregnant, how many weeks?

Have you had massage therapy before? *

Options: *Yes — regularly / Yes — a few times / No — first time*

Areas to avoid during massage

Injuries, sensitive areas, personal preference...

Client Signature: _____

Date: _____

Print Name: _____