

# Words & Bodyworks Massage Therapy: Intake Form

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## Personal Information:

To help us serve your massage needs, please answer the questions honestly. Any information provided is confidential.

Name \_\_\_\_\_ Best Contact Number (     ) \_\_\_\_\_ Home ( ) Cell ( )  
Address \_\_\_\_\_ City, State & Zip \_\_\_\_\_  
Birth date \_\_\_\_\_ Email \_\_\_\_\_

May we contact you with special offers and updates? YES ( ) NO ( )

How did you hear about us? SPRING TIDES ( ) Web search ( ) Referral ( ) Craigslist ( ) Other: \_\_\_\_\_

1. Have you had a professional massage before? Yes No

If yes, how often do you receive massage therapy? Weekly ( ) Monthly ( ) Annually ( ) Sporadically ( )

2. What prevents you from getting a massage more often, if anything? Finances ( ) Scheduling ( )

Other (please explain) \_\_\_\_\_

3. Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain \_\_\_\_\_

4. Do you have any allergies to oils, lotions, or scents? Yes No

If yes, please explain \_\_\_\_\_

5. Do you perform any repetitive movement in your work, sports, or hobbies? Yes No

If yes, please describe \_\_\_\_\_

6. What are your therapeutic goals for this massage session? \_\_\_\_\_

## Medical History:

To plan a massage session that is safe and effective, we require some information about your medical history.

11. Are you currently under a physician's care? Yes No

If yes, physician's name \_\_\_\_\_ Contact # (     ) \_\_\_\_\_

12. Are you currently taking any medications? Yes No

If yes, please list \_\_\_\_\_

13. Please check any condition listed below that applies to you:

( ) contagious skin condition

( ) open sores or wounds

( ) bruising

( ) recent accident or injury

( ) recent fracture

( ) recent surgery

( ) artificial joint

( ) sprains/strains

( ) current fever

( ) swollen glands

( ) decreased sensation

( ) back/neck problems

( ) Fibromyalgia

( ) TMJ

( ) carpal tunnel syndrome

( ) tennis elbow

( ) pregnancy – How many weeks? \_\_\_\_\_

( ) atherosclerosis

( ) heart condition

( ) high or low blood pressure

( ) circulatory disorder

( ) varicose veins

( ) phlebitis

( ) deep vein thrombosis/blood clots

( ) joint disorders

( ) osteoporosis

( ) epilepsy

( ) headaches/migraines

( ) cancer: please elaborate: \_\_\_\_\_

( ) diabetes

( ) plantar fasciitis

( ) arthritis Where? \_\_\_\_\_

Other, please elaborate: \_\_\_\_\_

