

Massage Therapy Intake Form

Last name _____ First name _____ M.I. _____ Date _____

Street _____ City _____ State _____ Zip _____

Home ph: _____ Work ph: _____ Cell ph: _____

Will it be possible to text you? Y/N e-mail: _____

Age _____ Date of Birth _____ Gender: M/F

Employer _____ Occupation _____

Have you received massage before? Y/N

Why have you come for massage today?

____ Injury ____ Pain ____ Tension ____ Stress ____ Feels good

Are you currently:

Pregnant? Y/N Wearing Contacts? Y/N Cold or Flu? Y/N Taking medication? Y/N

Skin reactions to massage oil? Y/N

Injuries/Surgeries/Major Illnesses (dates):

Any of the follow? (circle)

Allergies	Diarrhea	Migraines	Swollen feet
Anemia	Dislocations	Muscle spasms	Tendonitis
Arthritis	Diverticulitis	Numbness	Tingling
Asthma	Epilepsy/seizures	Phlebitis	TMJ
Back pain	Eczema	Psoriasis	Varicose veins
Bunions	Headaches	Rashes	Whiplash
Bursitis	Heart attack	Respiratory problems	
Cancer	Hemophilia	Sciatica	<u>Women only:</u>
Circulatory issues	Herpes	Stiff joints	Excess bleeding
Colitis	HBP	Sprain/strain	Lack of periods
Constipation	HIV/AIDS	Excess stress	Menstrual cramps
Diabetes	LBP	Stroke	PMS

Mark E. Hughes, L.M.P

10508 Whitman Ave. N. #D, Seattle, WA 98133

(425)761-8321 mark@massage911.com