Personal Information

BODY CENTRAL

Date ____/____/_____

Massage Intake Form

Name	
Phone	
Occupation	
E-mail address	
Date of birth	
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 serious injuries? ☐yes ☐no

If yes, please list: _____

_____

Please indicate any condition you have had in the past or currently have.

☐Cancer
☐Headaches/Migraines
☐Arthritis
☐Diabetes
☐Joint Replacement(s)
☐High/Low Blood Pressure
☐Neuropathy
☐Fibromyalgia
☐Stroke
☐Heart Attack
☐Kidney Dysfunction
☐Blood Clots
☐Numbness
☐Sprains or Strains

Explain any conditions you have marked above:

_____

_____

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

Are you sensitive to any fragrances? ☐yes ☐no

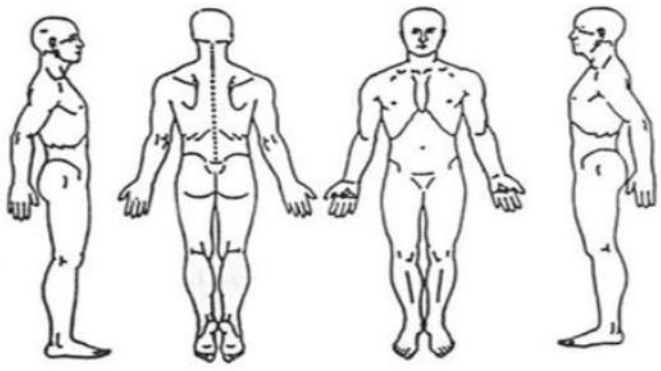
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐yes ☐no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



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 _____