



Massage Intake Form

Name _____ Date ____ - ____ - ____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ Phone (W)/(C) _____ Birth Date ____ - ____ - ____

Email _____ Occupation _____

Emergency Contact _____ Phone _____

Primary Reason for Massage (i.e. manage pain, relieve discomfort, maintain health, reduce stress, simply relax, etc.):

Have you ever had a professional massage before? Yes No

Would you like me to avoid any specific area(s) for health reasons, or any areas you simply do not wish or like to have massaged?

(please indicate): _____

What type of massage pressure do you typically enjoy? Light Medium Firm Deep Tissue

Your Health Information (please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis/Bursitis | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Back/Neck Injury | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hypertension/High Blood Pressure | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Spinal Injury |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epileptic/Seizures | <input type="checkbox"/> Nausea | <input type="checkbox"/> Varicose Veins |

Client Agreement

Please read the following statement and sign and date on the line to indicate that you have read and understand the statement.

I understand that massage therapy involves neither diagnosis nor treatment of illnesses or injuries and it is not a substitute for medical care. I am solely responsible for my physical condition and for seeking medical treatment when I feel it is necessary for my well-being.

I am aware that failure to alert my therapist to any of these conditions could result in adverse effects. I hereby voluntarily assume all such risks of loss, damage, or injury that my may be sustained. In consideration of participating, I hereby waive any and all claims of personal injury I might now or in the future have against Dallas Relaxing Massage or any of their affiliates, including but not limited to the following: (1) Illness; (2) Injury; or (3) Disablement, however caused, related directly or indirectly to my participation. This release shall be binding upon the undersigned, his/her heirs, next of kin, and personal representatives.

Types of massage techniques the therapist anticipates using during the session include, but are not limited to: acupressure massage, carpal tunnel massage, craniosacral therapy, deep tissue massage, facelift massage, hot stone massage, lymphatic drainage, medical massage, myofascial release, neuro muscular therapy, pregnancy/prenatal massage, reflexology, Reiki, sports massage, Swedish massage, Thai massage, TMJ, trigger point massage, and Other: _____

Body parts to be massaged include the face, neck, shoulders, back, arms, buttocks, hip flexors, legs (front and back), pectorals, abdominals, ribs, and feet.

The massage therapist will NOT engage in breast massage. Genitals are always excluded.

Standard draping will be used, meaning only the body part being massaged will be exposed.

Signature _____ Date _____

Therapist _____ Date _____