

Balanced Body Massage

Massage Intake Form

Name(Please Print)_____Date_____

Address_____City_____State_____Zip_____

Email:_____Phone#_____DOB_____

Occupation:_____ Emergency Contact (Name & Phone) _____

1) How did you hear about Balanced Body Massage?_____

2) Have you ever had a massage before? Yes / No If So, When?_____

3) What are you hoping to achieve with massage? Are there any areas to focus on or avoid?

4) Are there any current conditions that I should be aware of?_____

5) Do you have any allergies?_____

6) May we contact your doctor if a safety consult is required?_____

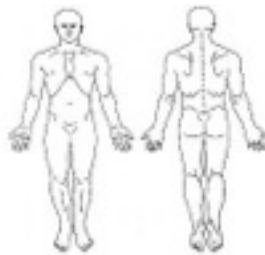
7) Please list any medications/supplements/herbs you currently take:

8) Have you ever had any forms of cancer? Yes / No If so, please list type, dates, and current status:

9) Have you had any lymph nodes removed? Yes / No If so, where?_____

10)Please list any surgeries/injuries I should be aware of:_____

11)Please circle the areas of discomfort and areas you would like to focus on:



By signing below I declare that, to the best of my knowledge, the above information is accurate. According to informed consent, I acknowledge that I am aware of the possibility of soreness following the massage. I am also aware that any massage will be NON-sexual in nature. At any time the therapist or client feels uncomfortable the massage may be terminated immediately.

Client Name Printed

Licensee's Name Printed

Client Signature

Date

Licensee's Signature

Date

Thank You!