Massage/Fascial Intake Form Date:

Name: _____ Phone (Day): _____ Cell:_____

Address: _____

City/Prov/Postal Code: _____

Email: _____ Date of Birth: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

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 orthopedic 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 replacements
___high/low blood pressure
___neuropathy
___fibromyalgia
___stroke
___heart attack
___kidney dysfunction
___blood clots
___numbness
___sprains or strains

Explain any condition 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

What pressure do you prefer?
__light __medium __deep

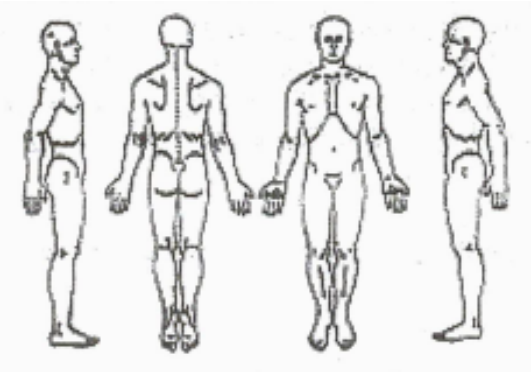
Are you sensitive to any fragrances? ___yes ___no

Are there any areas (feet, face, abdomen, etc.) you do not want massages? ___yes ___no

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.

_____

Movement Performance and Health
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