915 Southwest Blvd. Suite H
Phone: 573-635-2225

Jefferson City, MO 65109
Fax: 573-634-5155

MASSAGE THERAPY INTAKE FORM

Client Data

Name:		Date:
Address:		Gender: M F
City:	State:	Zip:
Birthday:	Age:	Phone: ( )
Emergency Contact:	Relationship:	Phone: ( )
How did you hear about our massage services?		

Health History

Do you have any physical conditions, pain or disease that the massage therapist should be aware of?	Yes	No
If yes please list:		
Are you currently taking any prescription medications?	Yes	No
If yes please list:		
Have you had any broken bones or surgeries in the last year?	Yes	No
If yes list when and the location of your injury:		
Do you have any allergies?	Yes	No
If yes please list:		
Are you currently under a Doctor's care?	Yes	No
If yes please explain:		
Are there any areas of the body that you would like the massage therapist to spend more time on?	Yes	No
If yes please list:		
Are there any areas of the body the massage therapist should avoid due to medical or personal reasons?	Yes	No
If yes please list:		
Have you ever experienced a professional massage before?	Yes	No

Massage Pressure Preferred

Soft/Relaxation Medium Medium/Firm Deep Tissue ($5 extra)

Signature of Client, Parent of Guardian_____ Date:_____