**Laura Sebastian LMT ~ Massage Therapy Intake Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Name and Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Medical Information**Are you taking any medications? Yes No - If yes, please listAre you currently pregnant? Yes No - If yes, how long?- Any high-risk factors?Do you suffer from chronic pain? Yes No-If yes please explain-What makes it better?Have you had any major injuries or surgeries? Yes No-If yes, please list what/whenDo you have any allergies? -please listPlease indicate any condition you have had in the past or currently have:Headaches/migraines Jaw Pain/TMJArthritis TendonitisSkin Conditions DiabetesHigh/Low BP Herniated/bulging discCancer EdemaVaricose veins Sleep difficultiesFibromyalgia AnxietySprains/Strains Numbness |  |  **Massage Information**Have you had professional massage before? Yes No-If yes, how long ago was your last massage?What is your major area of concern?How long have you had this issue?What are your goals and what type of massage are you seeking? (Circle all that apply)Relaxation Stress Reduction Pain ReductionGentle pressure Medium pressure Deep pressureAre there areas you would like focused on, and more time spent on? If so, where?Are there areas you would like NOT massaged? (For example, feet, face, head, abdomen, etc.)Are you sensitive to any fragrances? Yes NoIf yes, which ones?Please circle any areas of discomfortA diagram of a human body  Description automatically generated with low confidence |

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. I understand massage therapy is not a substitute for medical care. If I experience any pain or discomfort, I will immediately communicate this to the therapist so the treatment can be adjusted.
Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_