Healing Angel Massage Intake Form

Name: _____ Phone (day)_____(evening)_____
Address: _____ City/State/Zip:_____DOB:_____
Occupation: _____ Employer: _____
Email: _____ Primary Physician: _____
Emergency Contact: _____ Relationship:_____ Phone: _____

How did you hear about us?_____

Medical Information

Are you taking any medications? ❑ Yes ❑ No
Is 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 Replacement
- ❑ Fibromyalgia
- ❑ Neuropathy
- ❑ High/Low Blood Pressure
- ❑ Stroke
- ❑ Heart Attack
- ❑ Kidney Dysfunction
- ❑ Blood CLots
- ❑ Numbness
- ❑ Sprains or Strains

Please explain any conditions you have marked above:

Massage Information

Have you had a professional massage before? ❑ Yes ❑ No

What type of massage are you seeking? ❑ Yes ❑ No
Other:

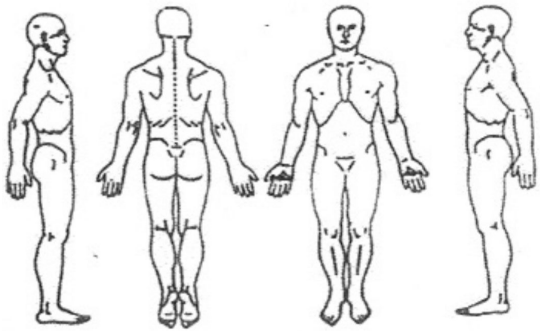
What pressure do you prefer?
❑ Light ❑ Medium ❑ Deep

Are you sensitive to any fragrances? ❑ Yes ❑ No

Are there areas that you do not want massaged? ❑ Yes ❑ No
)ie: feet, face, abdomen, etc)?
Please explain:

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.
I agree to inform my therapist if any of the above information changes at any time.
Client Signature: _____ Date: _____