

## Massage Intake Form

### Personal Information

Name \_\_\_\_\_ Phone number \_\_\_\_\_ Date \_\_\_\_\_

### 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 of the following that apply to you.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> Sprains or Strains |

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?  
 Relaxation     Therapeutic  
 \_\_\_\_\_

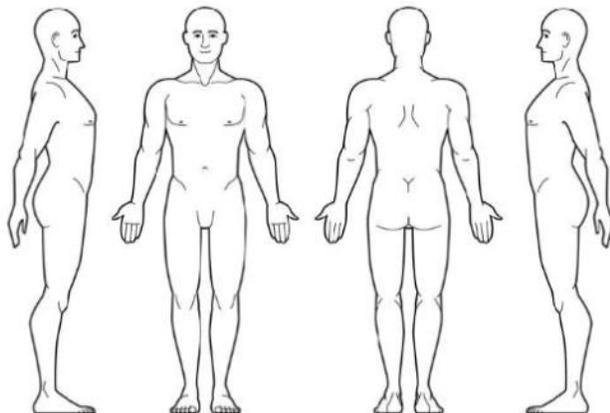
What pressure do you prefer?  
 Light             Medium

Do you have any allergies or sensitivities?     yes     no  
 Please explain \_\_\_\_\_

Are there any areas (feet, face, abdomen, etc.)  
 you do not want massaged?     yes     no  
 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 and  
 agree to inform my therapist if any of the above information changes at any  
 time.*

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

## Massage Add On Services

Please check mark any add on services you may be interested in doing.

### ***Aromatherapy***

Use of essential oils to enhance the psychological and physical well-being.

\$5.00 \_\_\_\_\_

### ***Deep Tissue***

Used to release chronic muscle tension.

\$15.00 \_\_\_\_\_

### ***Hot Stone***

Used to help relax and ease tense muscle and damaged soft tissues.

\$15.00 \_\_\_\_\_

### ***Cupping***

Combination of massage movements and negative pressure with the use of a suction device on the skin.

\$15.00 \_\_\_\_\_

### ***Prenatal***

Used during pregnancy to reduce stress and promote overall wellness.

\$15.00 \_\_\_\_\_

### ***Lomilomi Hawaiian Massage***

Long flowing dance like strokes promoting harmony and balance in your body.

\$25.00 \_\_\_\_\_

### ***Reflexology***

Application of pressure to the feet and hands to target specific body organs and systems.

\$15.00 \_\_\_\_\_

### ***Hot Towel-Cold Stone Face Massage***

To stimulate circulation and reduce inflammation.

\$10.00 \_\_\_\_\_

### ***Steam Room***

To help with overall detoxification of the body.

\$10.00 \_\_\_\_\_

# s.o.a.p notes

client name \_\_\_\_\_

session type \_\_\_\_\_

duration \_\_\_\_\_

date \_\_\_\_\_

## soap for relaxation massage

- s:** Goals for Session
- o:** Techniques Applied
- a:** Comments
- p:** Follow-up

## soap for medical massage

insurance ID number \_\_\_\_\_

date of injury \_\_\_\_\_

modality type (code) \_\_\_\_\_ duration \_\_\_\_\_

modality type (code) \_\_\_\_\_ duration \_\_\_\_\_

current medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### s: Functional Goals

activities affected by condition \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### o: Visual/Palpable Findings, Modalities

\_\_\_\_\_

\_\_\_\_\_

### a: Resulting Subjective and Objective Changes

\_\_\_\_\_

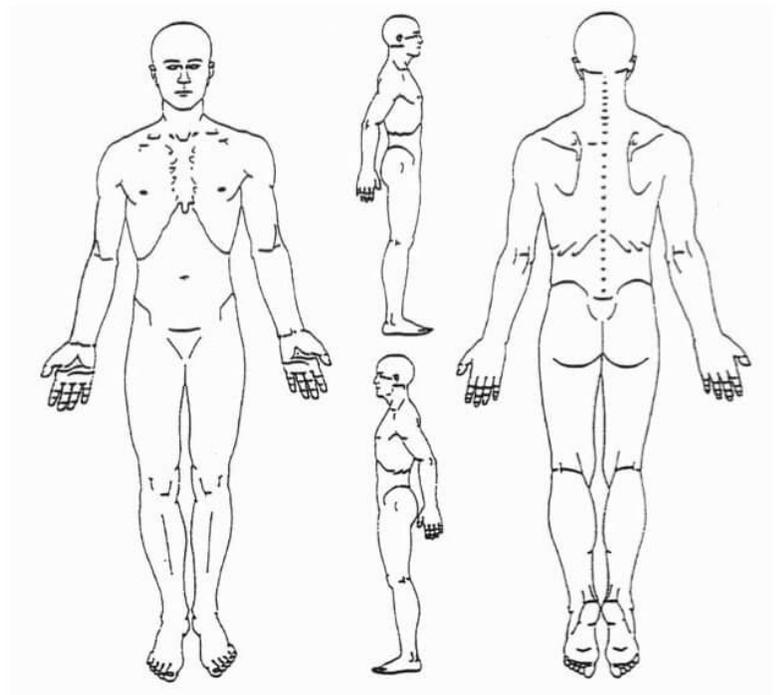
\_\_\_\_\_

### p: Massage Plan/Self Care Homework

\_\_\_\_\_

\_\_\_\_\_

## symptoms: location/intensity/duration/frequency/onset



|                   |                 |
|-------------------|-----------------|
| <b>X</b> Adhesion | ≈ Spasm         |
| ↻ Rotation        | ⚙️ Inflammation |
| ○ Pain            | 📍 Trigger point |
| ● Tender Point    | / Elevation     |
| ≡ Hypertonicity   |                 |