Felicia Pasquale, LMT

Healthy Life Transformations

Date:_____

Massage Intake Form

Personal Information

Name:_____ Phone (cell):_____ (home):_____

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

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?

If yes, please explain: _____

_____

What makes it feel better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please explain: _____

_____

Please indicate any condition you have had in the past or currently have.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Blood Clots
- ☐ Kidney Dysfunction
- ☐ Heart Attack
- ☐ Numbness
- ☐ 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/Deep Tissue

☐ Other: _____

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Are you sensitive to any fragrances? ☐ yes ☐ no

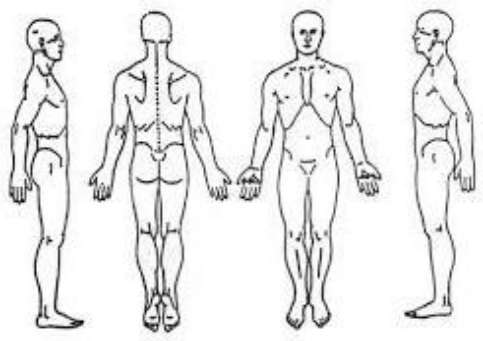
Are there any areas you do not want massaged?

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: _____