Jennifer Rode, RN, LMT, LR

Massage Intake Form

Personal Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Occupation: _____ DOB: _____ Age: _____ Gender: _____

In Case of Emergency, Please Contact: _____

Emergency Contact Phone: _____

Were you referred: _____ If yes by whom:_____

History

Exercise Frequency: _____ Type of Exercise: _____

Medications and/or Supplements you are taking: _____

Main areas of discomfort: _____

Goals for Massage Treatment today: _____

Have you had a massage before: _____ If yes, how long ago: _____

Are you pregnant? _____ If yes, how far along are you? _____

Are you sensitive to touch/pressure in any area? (ticklish?) _____

Do you have allergies? _____

List of surgeries (type and date):_____

Do you have any concerns or questions? _____

I understand that this massage is not a replacement for medical care and that no diagnosis will be made.

Signature: _____ Date: _____