Luminescence
THERAPEUTIC MASSAGE

Massage Intake Form

Personal Information

Name _____ Pronouns _____ Phone _____

Address _____ City/State/Zip _____

DOB _____ Email _____

Primary Physician _____ Phone _____

Emergency Contact _____ Relationship _____ Phone_____

Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use:

_____

_____

_____

_____

Are you currently pregnant? ☐ yes ☑ no

Do you suffer from chronic pain? ☐ yes ☑ no

If yes, please explain _____

_____

_____

Please indicate any of the following that apply to you:

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Anxiety
- ☐ Other

Explain any conditions you have marked above:

_____

_____

_____

Massage Information

What are your goals for treatment?

_____

_____

_____

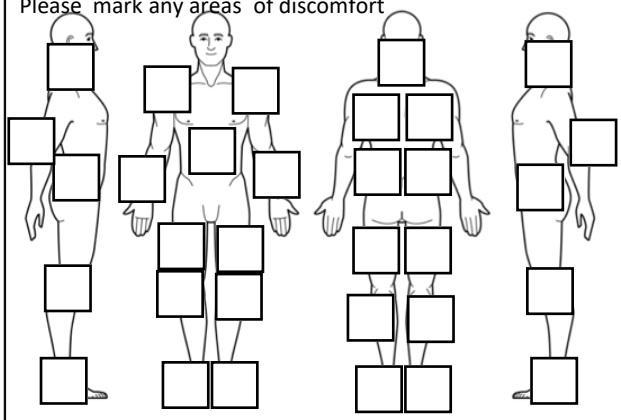
Do you have any allergies or sensitivities to topical oils or lotions? ☐ yes ☐ no

Please explain _____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

Please mark 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

Patient Signature: _____ Date: _____