

Superior Performance Wellness Center

Confidential Massage Intake Form

Name _____ Date ____ - ____ - _____ Gender M F

Phone (H) _____ (W/C) _____ Occupation _____

Email _____ Birth Date ____ - ____ - ____

Address _____ City _____ ST _____ Zip _____

Emergency Contact & Phone _____

Primary Reason for Massage (e.g., manage pain, relieve discomfort, maintain health, reduce stress, simply relax, etc.): _____

Have you ever had a professional massage before? Yes No
How recently? _____

Please check all that apply:

- Yes No Do you frequently suffer from stress?
 - Yes No Do you have diabetes?
 - Yes No Do you experience frequent headaches?
 - Yes No Are you pregnant?
 - Yes No Do you suffer from arthritis?
 - Yes No Are you wearing contact lenses?
 - Yes No Are you wearing dentures?
 - Yes No Do you have high blood pressure?
 - Yes No Do you suffer from epilepsy or seizures?
 - Yes No Do you suffer from joint swelling?
 - Yes No Do you have varicose veins?
 - Yes No Do you have osteoporosis?
 - Yes No Do you have any allergies, specifically topical? Please list: _____
 - Yes No Do you bruise easily?
 - Yes No Have you had any broken bones in the past two years?
 - Yes No Have you been in an accident or suffered any injuries in the past two years?
 - Yes No Do you have tension or soreness in a specific area?
- Please specify _____

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- Yes No Do you have cardiac or circulatory problems?
 - Yes No Do you suffer from back pain?
 - Yes No Do you have numbness or stabbing pains anywhere?
 - Yes No Are you very sensitive to touch or pressure in any area?
 - Yes No Have you ever had surgery? Explain below.
 - Yes No Do you have any type of implanted medical device?
 - Yes No Do you have any other medical condition your therapist should know about?
- Comments: _____

Yes No Are you taking any medications your therapist should know about, including transdermal patches? _____

