Woodside Therapeutic Massage
Client Intake Form

Name_____ DOB_____
Address_____
City_____Zip Code_____
Best Phone_____Email_____

Have you received Massage Therapy before? Yes No
What kind of pressure did you prefer? Light Moderate Firm Deep
Have you experienced any recent injuries or pain? If yes, where? When?

_____

_____

Have you had any surgeries? Y/N
Where? When?_____

_____

Would you like a specific area focused on? If yes, where?

_____

Would you like any specific areas avoided? Face, feet, scalp, … etc.

_____

Are you currently taking any medications? If yes, please list.

_____

Do you have any allergies? If yes, please list.

_____

Do you suffer from any major health issues? (heart or lung disease, high or low blood pressure, cancer, diabetes, … etc.)

_____

_____

_____

I _____, have answered this form to the best of my ability and will inform my massage therapist of any future changes in my health. I understand massage therapy is not a substitution for a doctor's care and understand my massage therapist cannot diagnose. I will abide by Woodside Massage's 24 hour cancellation policy.

Signature:_____
Date:_____