Massage Assessment Form

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Date of Birth: ___/___/_____ Occupation: _____

Emergency Contact: _____

Emergency Phone Number: _____ Relationship: _____

Referred by: _____

Have you had a professional massage before? ___ Yes ___ No If yes, how frequently do you get a massage? _____

_____

What are your expectations for today's massage session? _____

_____

Are you aware of any spots on your body that are holding tension? _____

_____

Please list any hospitalizations, accidents and or injuries that you have had: _____

_____

_____

Do you have any chronic and ongoing pain that you deal with on a regular basis? _____

_____

What activities cause this pain and or make it worse? _____

_____

Are you receiving any other type of medical treatment? _____

_____

What type of medications are you presently taking? _____

_____

_____

Are you currently under the care of a physician? ___ Yes ___ No If yes, please list physician and the reason for treatment: _____

_____

Please list any other health concerns that you would like to discuss today? _____

_____

_____

_____