# Massage Client Intake Form

AEF MASSAGE
RELAX. REFRESH. RECHARGE.

## Personal Information

Name_____ Phone_____ DOB_____

Address_____City/State/Zip_____

Occupation_____ Email_____

Emergency Contact_____Relationship_____Phone_____

How did you hear about AEF Massage? _____

## Medical Information

**Are you taking medication?** ○ Yes ○ No

If yes, list name and use_____

_____

**Are you pregnant?** ○ Yes ○ No

If yes, how far along? _____

Any high risk factors? _____

**Do you suffer from chronic pain?** ○ Yes ○ No

Briefly explain_____

_____

What makes it better?_____

_____

What makes it worse? _____

_____

**Have had any orthopedic injuries?** ○ Yes ○ No

If yes, please list: _____

**Indicate any of the following that apply to you.**

○ Cancer ○ Fibromyalgia ○ Stroke

○ Headaches/Migraines ○ Arthritis

○ Heart Attack ○ Diabetes ○ Blood Clots

○ Joint Replacement ○ Kidney Dysfunction

○ High/Low Blood Pressure ○ Numbness

○ Neuropathy ○ Sprains or Strains

***Explain any conditions you have marked above.***

## Massage Information

**Have you had a professional massage before?** ○ Yes ○ No

**What type of massage are you seeking?**

○ Relaxation ○ Therapeutic/Deep Tissue ○ Sports

**What pressure do you prefer?**

○ Light ○ Medium ○ Deep

**Do you have any allergies or sensitivities?** ○ Yes ○ No

Please explain_____

**Type of lubricant to be used?**

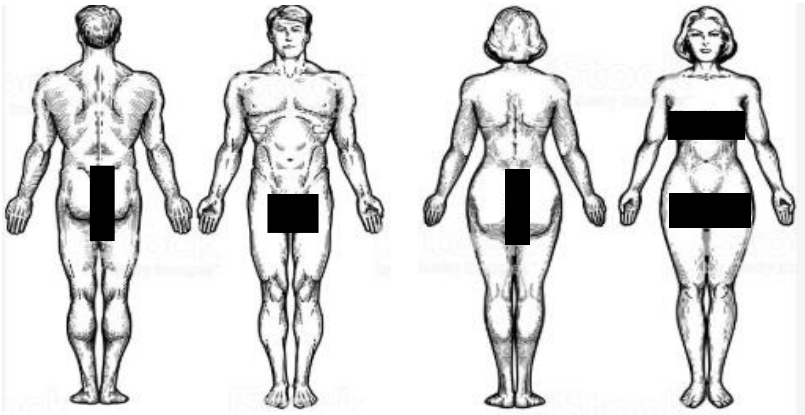
○ Organic Lotion ○ Gel ○ Use my own

**Type of draping do you prefer?**

○ Sheet Only ○ Sheet/Blanket ○ Lg. Towel

**Place an X on areas that you *DO NOT* want massaged.**

**Place a ○ on areas that you want addressed.**



***By signing below, you agree on the following.***

*I have completed this form to the best of my knowledge and agree to inform my therapist if any of the information above changes at any time.*

Client Signature_____ Date_____

Therapist Signature_____ Date_____