Massage Therapy Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Other

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ ☐ You may leave a voicemail and/or send text reminders to this number Email: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Massage Goals

Have you had massage therapy before? ☐ No ☐ Yes

Primary reason for massage: _____

Type preferred: ☐ Relaxation ☐ Deep Tissue ☐ Sports ☐ Other: _____

Preferred pressure: ☐ Light ☐ Medium ☐ Firm

Health History

Check all that apply: ☐ Headaches/Migraines ☐ Diabetes ☐ Arthritis ☐ Fibromyalgia

☐ Cancer ☐ Heart Condition ☐ Back Pain ☐ Neck Pain ☐ Shoulder Pain

☐ Joint Pain ☐ Recent Injury ☐ High Blood Pressure ☐ Low Blood Pressure

☐ Surgery (past 12 months) ☐ Pregnancy ☐ Skin Conditions ☐ Other: _____

Current Symptoms & Areas of Concern

Pain/Discomfort: ☐ Yes ☐ No Location: _____

Pain Level (0–10): _____

Activities that worsen symptoms: _____

Activities that relieve symptoms: _____

Authorization & Signature

I certify that the above information is true to the best of my knowledge. I authorize the release of any medical information necessary to process insurance claims. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature: _____ Date: ____ / ____ / ____

HIPAA Privacy Acknowledgement

I understand that this office follows all applicable privacy laws to protect my health information. I acknowledge that I have been informed of my right to review the full Privacy Practices policy (HIPAA Notice) and that a copy is available upon request.

Patient Signature: _____ Date: ____ / ____ / ____

Consent to Massage Therapy

I hereby request and consent to massage therapy services provided by the licensed massage therapist(s) of this clinic. I understand that massage therapy, like all forms of health care, carries some risks, including but not limited to temporary soreness, muscle strain, or in rare cases, more serious complications. I have had the opportunity to discuss these risks and have had all my questions answered.

Patient Signature: _____ Date: ____ / ____ / ____