FLOW Therapeutic Massage Intake Form

Name

……..... Date…….

Telephone Contact details

…….

Occupation

……

Sports and exercise (what and how often)……..

…….

……

Do you sit for long hours (driving, computers)?……

……..

Do you do heavy physical work/repetitive movements?…….

…….

Previous medical history/surgeries/medications taken……

……

……..

Reason for massage / preferred outcome…….....

……

……..

Pain and discomfort level on the scale of 1 (nothing) to 10 (excrutiating)……

How long did you have the issue?…….

What makes it better?……..

……

What makes it worse?……..

……

Have you been treated for it elsewhere? …….

……

Allergies or sensitivities……..

Anything else I should know?.....

……

……

Thank you