Active Life Therapeutic Massage – Intake Form
Oregon License # 21549

875 SE 3rd St, Suite 106 Bend, OR 97702
P- 541.480.1427 F- 541.833.0763

Client Name: _____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Emergency Contact:_____ Phone:_____

Occupation:_____ Hobbies:_____

Health Insurance Plan:_____ ID#_____

Have you had a professional massage before?: Yes No
Are you currently seeing a medical professional?: Yes No
Are you currently taking any medication (including aspirin or ibuprofen)?: Yes No
Please list if yes:_____

Have you had any surgeries or injuries in the last 10 years?: Yes No
Please list if yes:_____

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Do you have any allergies to any lotions, nuts, oils or food?: Yes No
Please list if yes:_____

What is your primary concern for today's session?: _____

Do you have any electrical devices implanted in your body?: Yes or No

How much pressure do you prefer?: Light Medium Hard

What is your pain level today?: 1 2 3 4 5 6 7 8 9 10

Please check any that apply:

_____Arthritis	_____Heart, Circulatory Problems	_____Scoliosis
_____Blood Clots	_____Herpes	_____Sleeping Disorders
_____Bursitis	_____High/Low Blood Pressure	_____Spinal Column Problems
_____Cancer, Tumors	_____HIV/AIDS	_____Sprains/Strains
_____Chronic Pain	_____Implants (breast, calves, gluts)	_____Stress
_____Depression	_____Muscle/Joint Pain	_____Tendinitis
_____Diabetes	_____Numbness/Tingling	_____TMJ, Jaw Pain
_____Digestive Problems	_____Pregnancy	_____Varicose Veins
_____Fibromyalgia	_____Rashes/Open Sores	_____Warts
_____Headaches	_____Respiratory Problems	

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_____Headaches	_____Respiratory Problems	

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Active Life Therapeutic Massage – Intake Form
Oregon License # 21549

875 SE 3rd St, Suite 106 Bend, OR 97702
P- 541.480.1427 F- 541.833.0763

Client Name: _____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Emergency Contact:_____ Phone:_____

Occupation:_____ Hobbies:_____

Health Insurance Plan:_____ ID#_____

Have you had a professional massage before?: Yes No
Are you currently seeing a medical professional?: Yes No
Are you currently taking any medication (including aspirin or ibuprofen)?: Yes No
Please list if yes:_____

Have you had any surgeries or injuries in the last 10 years?: Yes No
Please list if yes:_____

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Do you have any allergies to any lotions, nuts, oils or food?: Yes No
Please list if yes:_____

What is your primary concern for today's session?: _____

Do you have any electrical devices implanted in your body?: Yes or No

How much pressure do you prefer?: Light Medium Hard

What is your pain level today?: 1 2 3 4 5 6 7 8 9 10

Please check any that apply:

_____Arthritis	_____Heart, Circulatory Problems	_____Scoliosis
_____Blood Clots	_____Herpes	_____Sleeping Disorders
_____Bursitis	_____High/Low Blood Pressure	_____Spinal Column Problems
_____Cancer, Tumors	_____HIV/AIDS	_____Sprains/Strains
_____Chronic Pain	_____Implants (breast, calves, gluts)	_____Stress
_____Depression	_____Muscle/Joint Pain	_____Tendinitis
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