

Digital Massage Intake Form

Client Information:

- Full Name: _____
- Date of Birth: _____
- Contact Number: _____
- Email Address: _____

Appointment Details:

- Preferred Date: _____
- Preferred Time: _____

Health Information:

- Do you have any current medical conditions? [Yes/No] If yes, please specify: _____
- Are you on any medications? [Yes/No] If yes, please list:

- Do you have any allergies? [Yes/No] If yes, please describe:

Massage Preferences:

- Preferred Pressure: Light Medium Firm
- Areas of Focus: _____
- Areas to Avoid: _____

I confirm that the information provided is accurate and agree to the terms of the massage session.

Signatures:

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____