THE URBAN UNWIND
Feel the Change

MASSAGE INTAKE FORM

Personal Information

Name _____ Phone _____
Address _____ City/State/Zip _____
DOB_____Occupation_____Email_____
Emergency Contact _____ Relationship _____ Phone _____

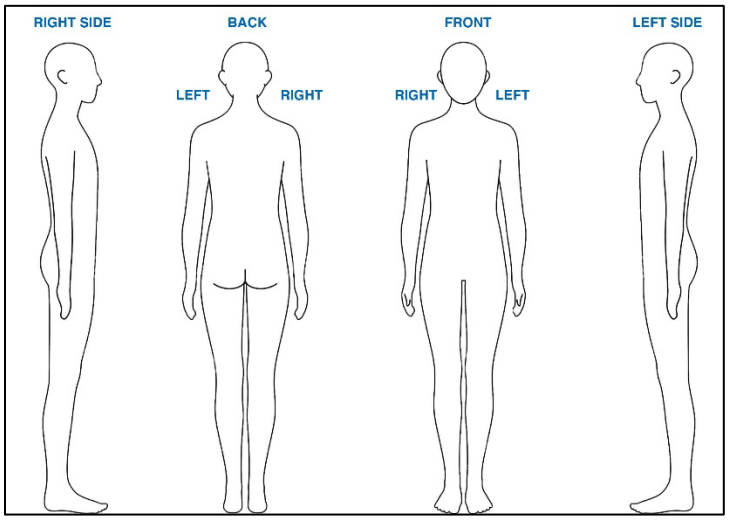
Medical Information

Are you taking any medications? ☐ yes ☐ no
If yes, please list name and use: _____ _____ _____
_____ _____ _____

Are you currently pregnant? ☐ yes ☐ no
If yes, how far along? _____ Any high risk factors? _____
Do you suffer from chronic pain? ☐ yes ☐ no
If yes, please explain _____
What makes it better? _____
What makes it worse? _____
Have you had any orthopedic injuries? ☐ yes ☐ no
If yes, please list: _____

Please indicate any of the following that apply to you:
☐ Cancer
☐ Headaches/Migraines
☐ Arthritis
☐ Diabetes
☐ Joint Replacement(s)
☐ High/Low Blood Pressure
☐ Neuropathy
☐ Fibromyalgia
☐ Stroke
☐ Heart Attack
☐ Kidney Dysfunction
☐ Blood Clots
☐ Numbness
☐ Sprains or Strains
Explain any conditions you have marked above including any NOT listed_____
_____
_____
_____
_____

Please mark any areas of discomfort:



Massage Information

Have you had a professional massage before? ☐ yes ☐ no
What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/Deep Tissue
Other _____
What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep
Do you have any allergies or sensitivities? (i.e. scents) ☐ yes ☐ no Please explain _____
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no
Please explain _____
What are your goals for this treatment session?_____

COVID-19 Information

1. Have you had a fever of 100° or above in the last 24 hours? ☐ yes ☐ no
2. Do you now, or have you recently had respiratory of flu like symptoms, sore throat or shortness of breath? ☐ yes ☐ no
3. Do you now, or have you recently had chills, muscle aches, new loss of taste or smell or new rashes? ☐ yes ☐ no
4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has corona Virus type symptoms? ☐ yes ☐ no

By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

The Urban Unwind, LLC
1726 Altamont Ave
Richmond, VA 23230
443-838-4646