



RnR Massage, LLC
Intake Form

Name _____

Address _____

Telephone-Work _____

Telephone-Home _____

E-Mail Address _____

Emergency Contact _____

Date of Birth _____

Have you received any professional bodywork? Yes No
If so, what kind?

What are you looking to get out of this work?

Health Survey:

Do you wear contact lenses? Yes No

Do you exercise regularly? Yes No

If yes, what is your regimen?

If female, are you pregnant? Yes No

Are you currently under a doctor's care? Yes No

If yes, for what are you being treated?

Please list any surgeries and their dates:

Are you currently taking any medication? Yes No

If yes, please list medication and reason for taking it:

Have you ever broken or fractured any bones? Yes No

Any sprains or strains?

Yes No

If yes, please describe and give dates:

Please list any allergies:

Please list any other issues you feel are important for me to know:

Please indicate below where you feel tension

