

Name: _____

Date _____

Message Therapist: _____
Entered in Booker By: _____ Date: _____



Cupping Intake Form - Confidential Information

Name _____ D.O.B. _____

Address _____

Phone (C) _____ (H) _____ Email _____

Occupation _____

Referred by _____ How did you hear about us? _____

In case of Emergency contact _____ Phone _____

Why are you here for a session today? _____

What are your goals/expectations for this therapy session?

Have you had professional bodywork before? **Y / N** What kind? _____

Are you currently taking any medications? **Y/N**

If yes, please list name & reason for medications: _____

MEDICAL INFORMATION

Do you have, or have you had a history of any of the following? Please *✓*

Headaches		Asthma		Arthritis		High Blood Pressure		Other _____
Epilepsy		Diabetes		Insomnia		Circulatory Problems		Other _____
Joint Pains		Allergies		Cancer		Digestive Problems		Other _____
Sinusitis		Constipation		Varicose Veins		Cardiac Problems		Other _____

Are you pregnant? _____ Y / N

Describe your general health _____

Have you had any recent illnesses? _____

Have you have any recent Injuries? _____

Have you had any recent surgeries? _____

Name: _____

Date _____

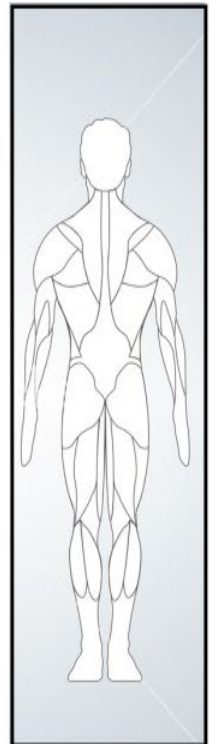
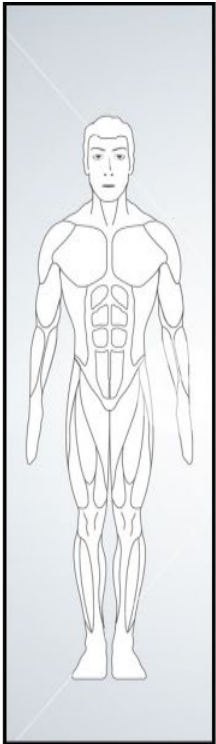
Do you have any medical conditions not mentioned here? (Skin Rash, Cold/Flu, Open Cuts, Severe Pain, Allergies) _____

Do you have any tension or soreness in specific areas? _____

Are you sensitive to touch/pressure in any area? _____

Is there anything else that you would like me to know? _____

Please circle any areas in which you are feeling discomfort:



Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and/or treatment.
2. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature: _____

Date: _____