Sione Wellness Center,LLC

710 W. Princeton St, Ste C
Orlando, FL 32804

Phone: 407.447.9017

Massage Intake Form

Personal Information

Name ______________________ Phone (day) ______________ (evening) ______________

Address ______________________ City/State/Zip ______________________ DOB __________

Occupation ______________________ Employer ______________________

Email ______________________ Primary Physician ______________________

Emergency Contact ______________________ Relationship ______________ Phone ______________

How did you hear about us? ______________________

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:

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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? ☐ yes ☐ no

Please explain ______________________

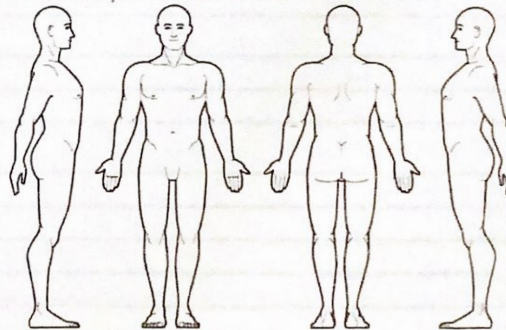
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain ______________________

What are your goals for this treatment session?

____

Please circle any areas of discomfort



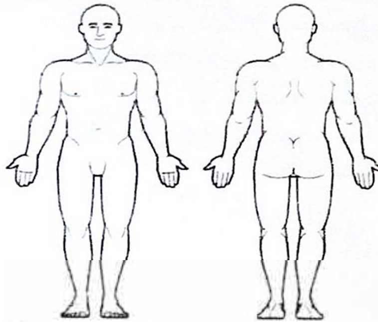
By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature ______________________ *Date* __________

Therapist Signature ______________________ *Date* __________

SOAP Notes

Patient Name ______________________________



Inflammation ★ Rotation ↺ or ↻ Long ⟷

Tender Point ● Trigger Point ✖ Elevation ⬆

Subjective ______________________________

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Objective ______________________________

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Assessment ______________________________

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Plan ______________________________

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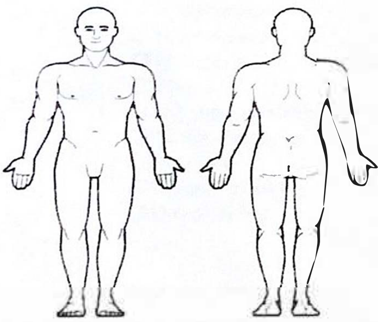
Signature ______________________________ *Date* ____________



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Subjective ______________________________

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Objective ______________________________

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Plan ______________________________

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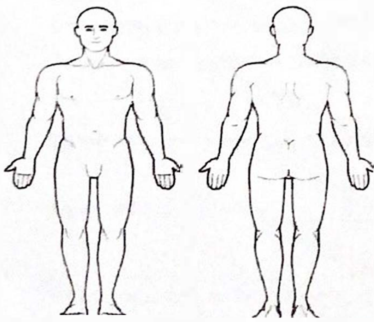
Signature ______________________________ *Date* ____________



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Subjective ______________________________

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Objective ______________________________

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Assessment ______________________________

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Plan ______________________________

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Signature ______________________________ *Date* ____________