Massage Intake Form

Personal Information

Name Bron Waters Phone (day) 0448888183 (evening) _____

Address Moore Cl Cl City/State/Zip Fern NSW DOB 25/09/71

Occupation Manager Employer _____

Email _____ Primary Physician _____

Emergency Contact Dale Waters Relationship _____ Phone 0427713857

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 Lower back - right hip

What makes it better? massage

What makes it worse? bending over for periods

Have you had any orthopedic injuries? ☐ yes ☒ no

If yes, please list: _____

Please indicate any of the following that apply to you.

☐ Cancer	☐ Fibromyalgia
☐ Headaches/Migraines	☐ Stroke
☐ Arthritis	☐ Heart Attack
☐ Diabetes	☐ Kidney Dysfunction
☐ Joint Replacement(s)	☐ Blood Clots
☐ High/Low Blood Pressure	☐ Numbness
☐ Neuropathy	☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

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 _____

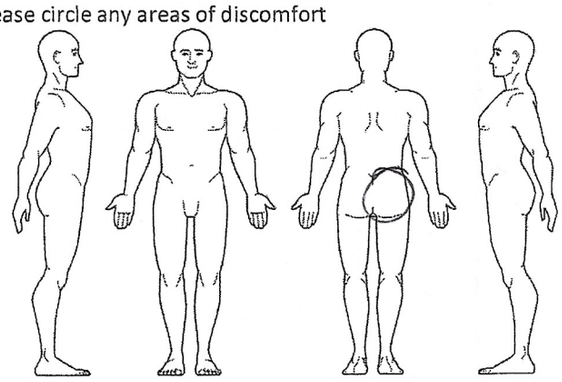
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

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* 14/12/23

Therapist Signature _____ *Date* _____