Client Intake Form - Therapeutic Massage

Client Information

Name Kayla Buchanan Email fairykayla17@gmail.com

Phone (cell/day) 0422579902 DOB 11/2/90 Age: 35

Address/015 Eulah Creek rd Eulah Creek City/State/Zip 2390

Emergency Contact Name Matthew Taylor Phone 0422077790 Relationship partner

Occupation — Referred by:

Health Information

Are you taking any medications? ☐ yes ☑ no If yes, please list:

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☑ no If yes, please list:

Are you pregnant? ☐ yes ☑ no If yes, how many months: Due date:

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☑ no

If yes, please describe:

Areas of swelling	yes (no)	Diabetes	yes (no)	Osteoporosis	yes (no)
Autoimmune disorder	yes (no)	Fibromyalgia	yes (no)	Phlebitis	yes (no)
Back / neck problems	(yes) no	Headaches	yes (no)	Sciatica	(yes) no
Bleeding disorders	yes (no)	Heart condition	yes (no)	Seizures	yes (no)
Blood clots	yes (no)	Hypertension	yes (no)	Stroke	yes (no)
Bruise easily	(yes) no	Kidney disease	yes (no)	Tendinitis	yes (no)
Bursitis	yes (no)	Multiple sclerosis	yes (no)	TMJ disorder	yes (no)
Cancer	yes (no)	Neurological condition	yes (no)	Varicose veins	yes (no)
Contagious condition	yes (no)	Neuropathy	yes (no)	Vertigo / dizziness	yes (no)
Decreased sensation	yes (no)	Osteoarthritis	yes (no)		

Areas of broken skin? (e.g. rash, wounds) ☑ yes ☐ no If yes, where? Tattoo, left arm

History of joint replacement surgery? ☐ yes ☑ no Which joint(s)?

Recent injuries or medical procedures in the past 2 years? ☐ yes ☑ no Please describe:

Please describe any other injuries or health conditions:

Massage Information

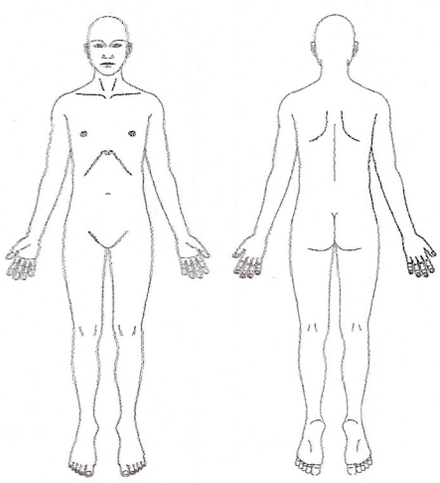
Have you had professional massage before? ☑ yes ☐ no How recently? years ago

Reason for seeking massage: ☑ Relaxation ☐ Specific problem

aches & pains from giving birth/constantly holding baby

How much pressure do you prefer? ☑ Light ☑ Medium ☒ Firm

Please indicate any areas of discomfort



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature KB Date 1/3/25

Therapist Signature Date 1/3/25