# Client Intake Form - Therapeutic Massage

## Client Information

Name Andrew Clements Email ~~andy~~ andrewclements825@gmail.com

Phone (cell/day) 0422 791 735 DOB 19.07.97 Age: 27

Address 33 Uralla St, Uralla St Fern Bay 2295 City/State/Zip

Emergency Contact Name Emma Devrell Phone 0434 397 779 Relationship Partner

Occupation Accountant Referred by: NA

## 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: Dust mites

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: Psychologist

| | | | | | |
|---|---|---|---|---|---|
| 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? Light scratch right shin.

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: Posterior fossa decompression.

## Massage Information

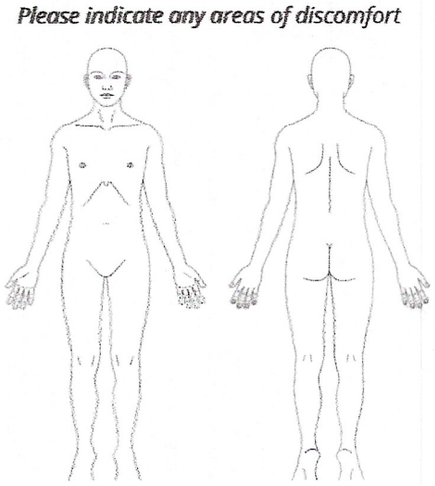
Have you had professional massage before? ☑ yes ☐ no How recently? 1 week ago (light relaxation)

Reason for seeking massage: ☐ Relaxation ☐ Specific problem

Tight / knotted back muscles

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 Date 27.9.24