Massage Intake Form

Personal Information

Name ANNA CHRISTIE Phone (day) 0425 322186 (evening) _____

Address 521 Kaputar Rd City/State/Zip 2390 DOB 3/12/55

Occupation researcher Employer _____

Email christieanna@me.com Primary Physician _____

Emergency Contact Geoff Relationship husband Phone 0413 104 264

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: knees .

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:

_____

_____

_____

_____

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 _____

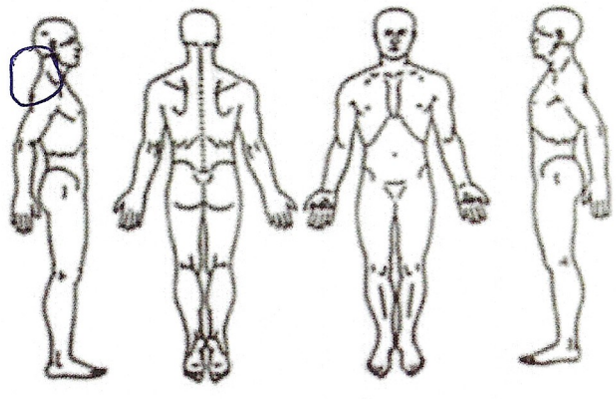
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

Please explain _____

What are your goals for this treatment session?

relief from neck/shoulder

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* _____

Massage Intake Form

Personal Information

Name ANNA CHRISTIE Phone (day) 0425 322186 (evening) _____

Address 521 Kaputar Rd City/State/Zip 2390 DOB 3/12/55

Occupation Researcher Employer _____

Email christieanna@me.com Primary Physician Dr Karley Heywood

Emergency Contact Geoff Petersson Relationship husband Phone 04/3 104264

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 L thumb injury

What makes it better? _____

What makes it worse? over-use

Have you had any orthopedic injuries? ☑ yes ☐ no

If yes, please list: Knee arthroscopy (both)

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
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Explain any conditions you have marked above:

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What are your goals for this treatment session?

_____

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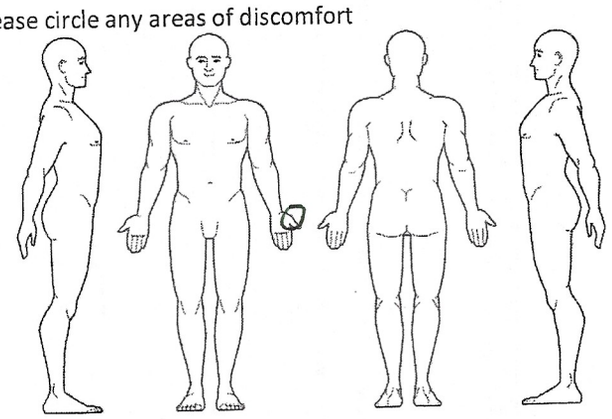

By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature Christie. *Date* 18 Oct 23

Therapist Signature _____ *Date* _____