Massage Intake Form

Personal Information

Name GREG CHEYNE Phone (day) 0419990579. (evening) _____

Address 16 ARAWA CRT City/State/Zip MAROOCHY DOB 31/1/57

Occupation RETIRED. Employer _____

Email gjcheyne@bigpond.net.au Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? TANYA.

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 KNEES HIPS BACK.

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:

prostate & Lukemia

_____

_____

_____

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 _____

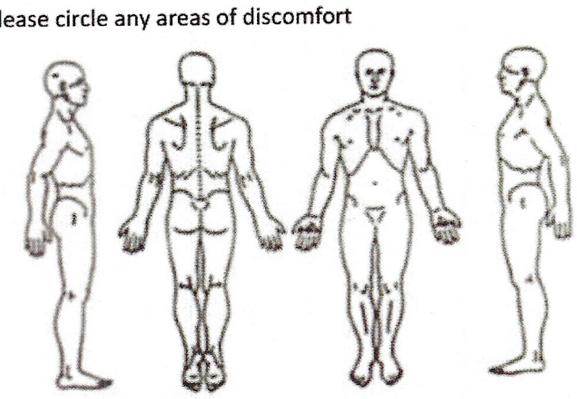
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

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* 21/8/24.

Therapist Signature _____ *Date* _____