Massage Intake Form

Personal Information

Name Grant Whiting Phone (day) 0417677370 (evening) _____

Address 13 Lenore St City/State/Zip NARRABRI NSW 2390 DOB 01.10.91

Occupation PERSONAL TRAINER Employer SELF

Email grantboi91@gmail.com Primary Physician _____

Emergency Contact Kait Whiting Relationship WIFE Phone 0449609609

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: _____

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:

Dislocated Knee / Reconstructed

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 _____

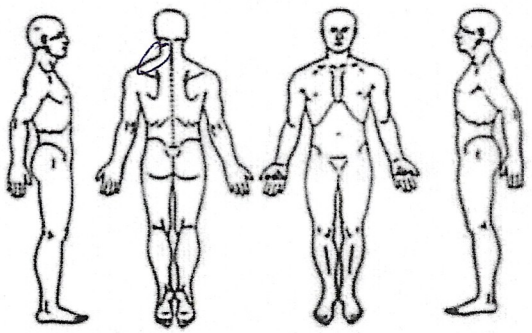
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

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 G Whiting *Date* 3.7.24

Therapist Signature _____ *Date* 3.7.24