

Client Intake Form - Therapeutic Massage

Client Information

Name Mandy Simpson Email link.simpson@hotmail.com
 Phone (cell/day) 0437 925358 DOB 25/09/76 Age: 48
 Address 604 Eulah Creek Road Eulah Creek City/State/Zip NSW 2390
 Emergency Contact Name Jason Simpson Phone 0438 925185 Relationship Husband
 Occupation Legal Assistant Referred by: Tania McDonald

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: Dairy

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

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

If yes, please describe: Chiropractor

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

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☒ no If yes, where? _____

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? 17 years relaxation

Reason for seeking massage: ☒ Relaxation ☐ Specific problem

Please indicate any areas of discomfort

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

I don't know.

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 [Signature] Date 19/2/25

Therapist Signature [Signature] Date 19/2/25

