MASSAGE & LYMPHATIC DRAINAGE ELTHAM

Poppy

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CLIENT INTAKE

Name Poppy McAlpine Age 40

Email mcalpine25@optusnet.com.au Mobile 0480402011

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- [ ] Arthritis / joint disorder
- [ ] Artificial joint
- [ ] Asthma
- [ ] Blood disorder
- [ ] Back/neck problems
- [ ] Cancer
- [ ] Carpal tunnel syndrome
- [ ] Circulatory disorder
- [ ] Decreased sensation
- [ ] Deep vein thrombosis
- [ ] Diabetes
- [ ] Easy bruising
- [ ] Eczema
- [ ] Epilepsy
- [ ] Fibromyalgia
- [ ] Fluid retention
- [ ] Headaches/migraines
- [ ] Heart condition
- [ ] High/low blood pressure
- [ ] HIV
- [ ] Immune disorders
- [ ] Keloid scarring
- [ ] Open sores or wounds
- [ ] Osteoporosis
- [ ] Pregnant
- [x] Recent accident/injury
- [ ] Recent fracture
- [ ] Seizures/epilepsy
- [ ] Skin disease/lesions
- [ ] Sprains/dislocations
- [ ] Strains
- [ ] Swollen glands
- [ ] Tennis/golfers elbow
- [ ] Thyroid issues
- [ ] TMJ
- [ ] Varicose veins

If you have selected any issues above, please provide details below;

surgery on left knee

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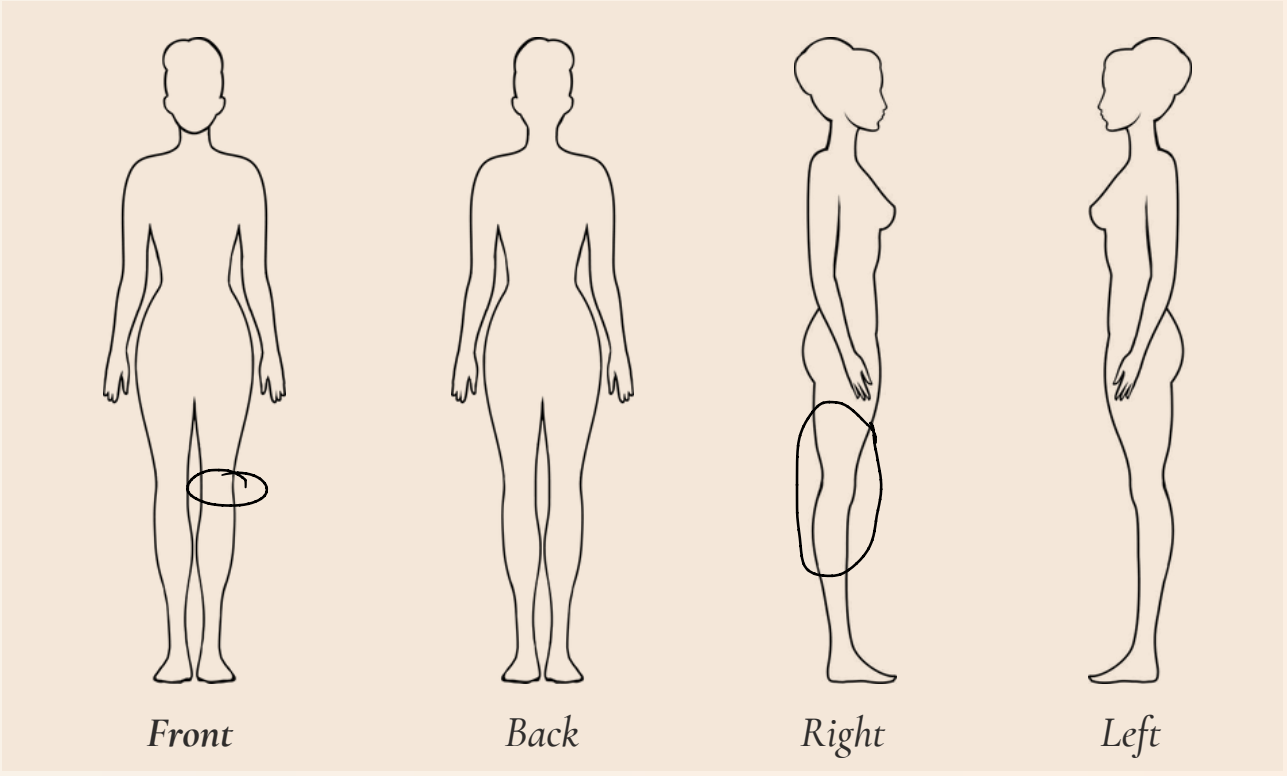
CLIENT INTAKE

	Y	N
Have you had a professional massage before?	✓	
Do you have difficulty lying on your front, back or side?		✓
Do you have allergies to oils, creams, lotions or ointments?		✓
Do you have sensitive skin?		✓
Are there any areas (ie feet, face) you do not want massaged?		✓

What type of massage are you seeking? ☐ Relaxation ☑ MLD ☑ Remedial

What pressure range do you prefer? ☐ Light-Medium ☑ Medium-Firm

Mark any specific areas you would like your therapist to concentrate on:



Front *Back* *Right* *Left*

Please provide details;

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CONSENT FORM

Poppy McAlpine

Client's Name

I have to the best of my knowledge, provided all relevant information about my health and medical history and I give my full consent to treatment.

I intend this consent to apply to all future treatments and I understand that I must update my service provider with any changes that may occur in my medical history.

I understand that a 50% cancellation fee may apply if I do not provide a minimum of 24 hours notice.

My signature acknowledges that I have read and agree to receive the massage therapy and that I will adhere to all of the aforementioned statements.

Poppy McAlpine		2/7/25
Client Name	*Client Signature*	*Date*
Tani Gray		2.7.25
Therapist Name	*Therapist Signature*	*Date*