

Client Intake Form - Therapeutic Massage

Client Information

Name Jordan Johnson Email Jordan mccluskey@hotmail.com
Phone (cell/day) 0421837930 DOB 26/12/92 Age: 32
Address 30 Maitland St Wee Waa City/State/Zip 2388
Emergency Contact Name Chris Johnson Phone 0407375332 Relationship Husband
Occupation Teacher Referred by: _____

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: _____

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: _____

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

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: _____

C-section.

Please describe any other injuries or health conditions: ACL surgery left and right
C sect x2

Massage Information

Have you had professional massage before? ☒ yes ☐ no How recently? 3 months ago

Reason for seeking massage: ☐ Relaxation ☒ Specific problem

Right hip + both calves.

Please indicate any areas of discomfort

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

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 8/1/24

Therapist Signature _____ Date _____

