Client Intake Form - Therapeutic Massage

Client Information

Name Nicole Shields Email nicoleshields1986@gmail.com

Phone (cell/day) DOB 17-12-86 Age: 38

Address 7 Thuringoona Ave Nunawading City/State/Zip

Emergency Contact Name Phone 0429944596 Relationship

Occupation Operator 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 you currently under medical supervision or receiving other medical interventions? ☐ yes ☑ no

If yes, please describe:

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

Please describe any other injuries or health conditions:

Massage Information

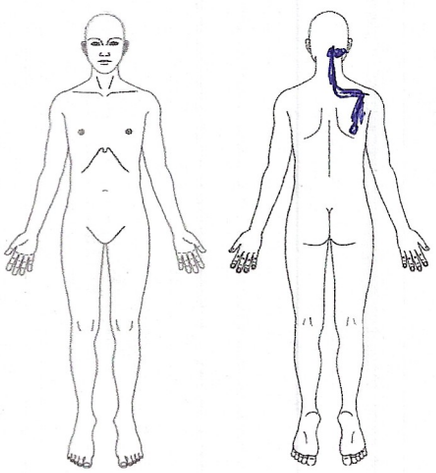
Have you had professional massage before? ☐ yes ☑ no How recently?

Reason for seeking massage: ☑ Relaxation ☑ Specific problem

sore neck right shoulder

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

Please indicate any areas of discomfort



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 Date 27.5.25

Therapist Signature Date 27/5/25