Massage Intake Form

Personal Information

Name Danna Warren Phone (day) 0455033997 (evening) _____

Address 26 Taylor St City/State/Zip NRK DOB 18/5/96

Occupation Sales Employer Haymans Elec.

Email danna.lee.18@hotmail.com Primary Physician _____

Emergency Contact Kurt Warren Relationship Husband Phone 0409780383

How did you hear about us? Friends

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
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

_____

_____

_____

_____

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 _____

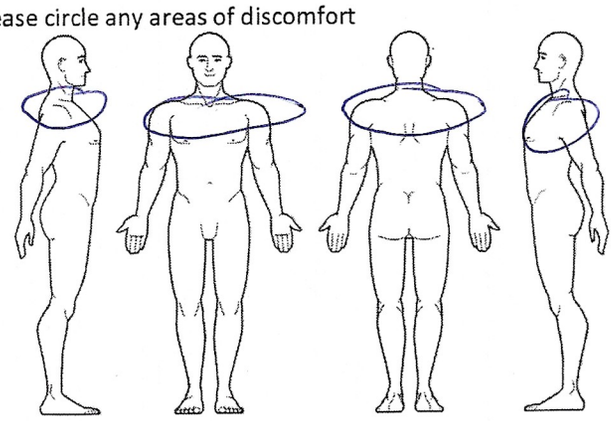
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

Please explain _____

What are your goals for this treatment session?

Relax

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 D. Warren *Date* 27/1

Therapist Signature _____ *Date* 27/1