Massage Intake Form

Personal Information

Name Lisa Bartlett Phone (day) 0411 610 894 (evening) _____

Address 28 Stone Cres City/State/Zip Baringa Qld 4551 DOB 10/8/73

Occupation Admin. Employer WTC.

Email Ld.ant.bartlett@gmail.com Primary Physician _____

Emergency Contact Darren Relationship Husband. Phone 0447 154 477.

How did you hear about us? Facebook.

Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use: HRT

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

Explain any conditions you have marked above:

N/A.

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 _____

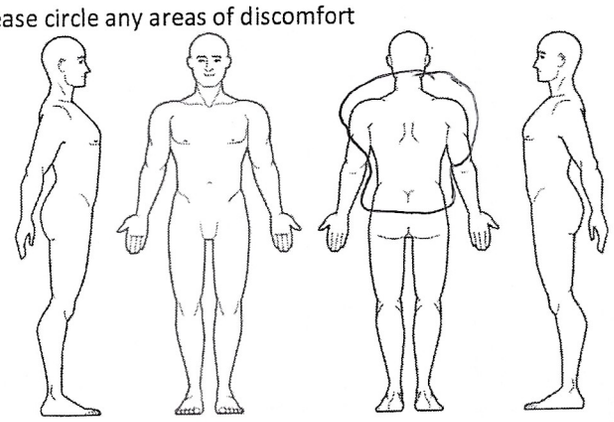
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

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 _____ *Date* 11/5/24.

Therapist Signature _____ *Date* _____