Massage Intake Form

Personal Information

Name Jillian Butler Phone (day) 0428233647 (evening) _____

Address 20 Byamee Lane City/State/Zip NSW DOB 27/7/82

Occupation _____ Employer _____

Email jillianbutler@outlook.com.au Primary Physician MyGP Tamworth

Emergency Contact Tim Connolly Relationship Partner Phone 0422880199

How did you hear about us? _____

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 Back pain

What makes it better? Massage

What makes it worse? Impact

Have you had any orthopedic injuries? ☑ yes ☐ no

If yes, please list: L5-S1 discectomy

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:

_____

_____

_____

_____

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 _____

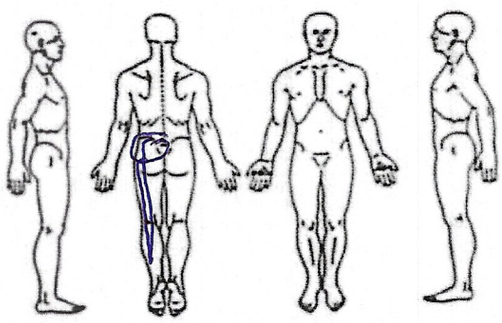
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

Please explain _____

What are your goals for this treatment session?

Release the Sciatic nerve

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 [signature] *Date* 19/6/24

Therapist Signature [signature] *Date* 19/6/24