Massage Intake Form

Personal Information

Name: Kim
Phone (day): 0428769427 (evening): ____
Address: 6 Ningadhun
City/State/Zip: Narrabri 2390
DOB: 13/8/72
Occupation: Domestic
Employer: Hospital Narrabri
Email: kimtiger@bigpond.com
Primary Physician: Dr OJah
Emergency Contact: Mark
Relationship: Married
Phone: 0428969427
How did you hear about us? FB

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 ____

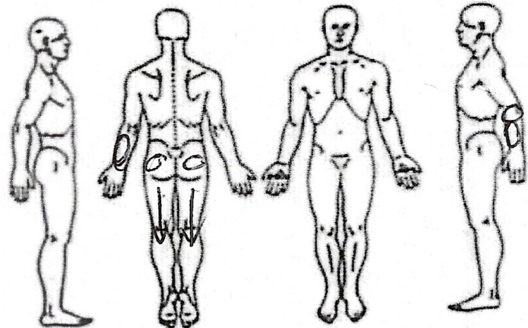
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

Please explain ____

What are your goals for this treatment session?

to get some knots out

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* 2/7/24

Therapist Signature ____ *Date* ____