Massage Intake Form

Personal Information

Name PATRICIA ANN CAMERON Phone (day) 0428 944 821 (evening) _____

Address 848 KAPUTAR RD City/State/Zip NARRABRI DOB 7-3-44

Occupation RETIRED Employer –

Email – Primary Physician DR. O. OJAH

Emergency Contact CATHY WALTERS Relationship D'TER Phone 0418 405 245

How did you hear about us? DAUGHTER

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 HIP

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:

STROKE CAUSED BY MIGRAINE

TYPE 2 DIABETES

PACE MAKER

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 _____

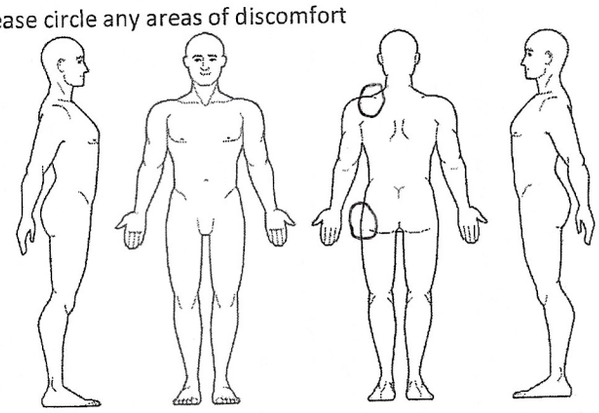
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

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 P. Cameron *Date* _____

Therapist Signature _____ *Date* _____