Massage Intake Form

Personal Information

Name Carmel Condon Phone (day) 0467923809 (evening) ______

Address 9 Burt St NARRABRI City/State/Zip NSW 2390 DOB 07/07/55

Occupation retired Employer ______

Email carmel.condon@hotmail.com Primary Physician NBH Bridge Medical Centre

Emergency Contact Ray Condon Relationship Husband Phone 0467921223

How did you hear about us? Word of mouth

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 ______

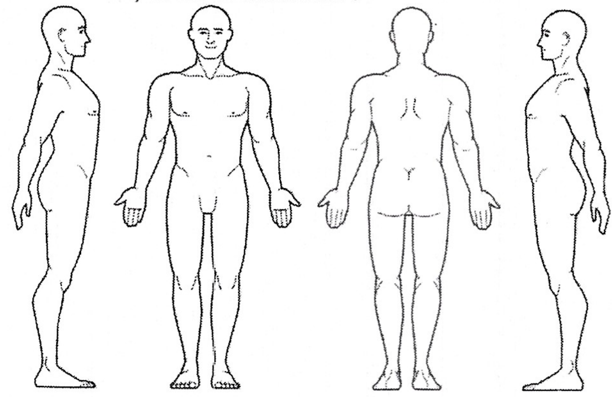
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

Please explain ______

What are your goals for this treatment session?

relaxation

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 C Condon *Date* 7/5/24

Therapist Signature [signature] *Date* 7/5/24