# Client Intake Form - Therapeutic Massage

## Client Information

Name Ashleigh Dudman Email adudman97@gmail.com

Phone (cell/day) 0758781898 DOB 27/1/97 Age: 28

Address 76 Baltonne Street Nairobi 2 City/State/Zip 2390

Emergency Contact Name Mark Rottger Phone 0447591414 Relationship Partner

Occupation teacher Referred by: family

## Health Information

Are you taking any medications? ☐ yes ☑ no If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☑ no If yes, please list: _____

Are you pregnant? ☑ yes ☐ no If yes, how many months: 37 weeks Due date: 19/2/25

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☑ no

If yes, please describe: _____

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Areas of swelling | yes | no | Diabetes | yes | no | Osteoporosis | yes | no |
| Autoimmune disorder | yes | no | Fibromyalgia | yes | no | Phlebitis | yes | no |
| Back / neck problems | yes | no | Headaches | yes | no | Sciatica | yes | no |
| Bleeding disorders | yes | no | Heart condition | yes | no | Seizures | yes | no |
| Blood clots | yes | no | Hypertension | yes | no | Stroke | yes | no |
| Bruise easily | yes | no | Kidney disease | yes | no | Tendinitis | yes | no |
| Bursitis | yes | no | Multiple sclerosis | yes | no | TMJ disorder | yes | no |
| Cancer | yes | no | Neurological condition | yes | no | Varicose veins | yes | no |
| Contagious condition | yes | no | Neuropathy | yes | no | Vertigo / dizziness | yes | no |
| Decreased sensation | yes | no | Osteoarthritis | yes | no | | | |

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☑ no If yes, where? _____

History of joint replacement surgery? ☐ yes ☑ no Which joint(s)? _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☑ no Please describe: _____

Please describe any other injuries or health conditions: _____

## Massage Information

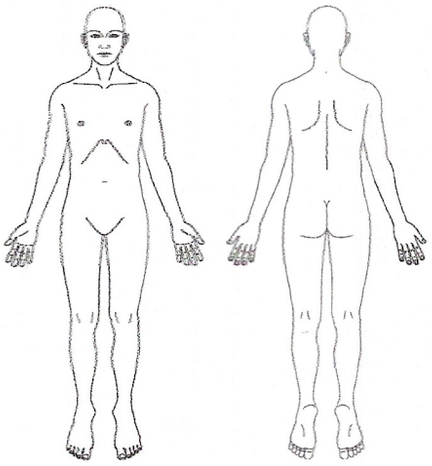
Have you had professional massage before? ☐ yes ☑ no How recently? _____

Reason for seeking massage: ☑ Relaxation ☐ Specific problem

_____

How much pressure do you prefer? ☐ Light ☑ Medium ☐ Firm

*Please indicate any areas of discomfort*



*By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.*

Client Signature Ashleigh Dudman Date 31/1/25

Therapist Signature _____ Date 31/1/25