

# Client Intake Form - Therapeutic Massage

## Client Information

Name Les Schofield Email lynscho@bigpond.com  
 Phone (cell/day) 0437110251 DOB 18/11/1953 Age: 71  
 Address 3. Harlequin Court CALLOPE City/State/Zip QLD 4680  
 Emergency Contact Name As Above Phone 0437110251 Relationship wife  
 Occupation Retired Referred by: Helen Gett

## 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: \_\_\_\_\_ Due date: \_\_\_\_\_  
 Are you currently under medical supervision or receiving other medical interventions?  yes  no  
 If yes, please describe: Metformin/Pantoprazole

Areas of swelling	yes no	Diabetes	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis	yes no
Autoimmune disorder	yes no	Fibromyalgia	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Phlebitis	yes no
Back / neck problems	<input checked="" type="checkbox"/> yes <input type="checkbox"/> 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		

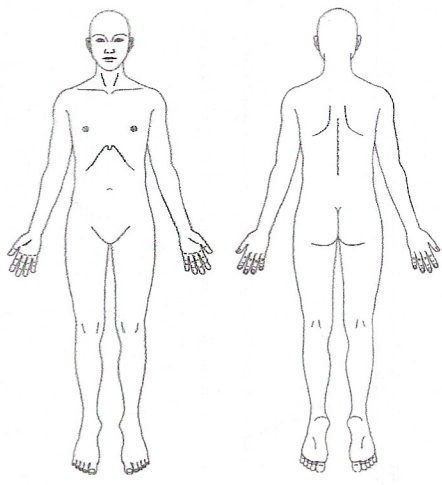
Areas of broken skin? (e.g. rash, wounds)  yes  no If yes, where? \_\_\_\_\_  
 History of joint replacement surgery?  yes  no Which joint(s)? Right Knee Replacement  
 Recent injuries or medical procedures in the past 2 years?  yes  no Please describe: Several Skin Cancer removals  
 Please describe 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 *Please indicate any areas of discomfort*

How much pressure do you prefer?  Light  Medium  Firm



*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 \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_