Client Intake Form - Therapeutic Massage

Client Information

Name Francis Drysdale Email drysdale51@bigpond.com

Phone (cell/day) 0427 675 315 DOB 6/8/195 Age: 73.

Address 497 Lake Circuit City/State/Zip 2358

Emergency Contact Name Beth Drysdale Phone 0427956168 Relationship wife.

Occupation _____ Referred by: _____

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: Coconut.

Are you pregnant? ☐ yes ☒ no If yes, how many months: _____ Due date: _____

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: _____

Rotator Cuff injury, ~~Tripple~~

Please describe any other injuries or health conditions: _____

High blood pressure, Tripple bypass 4 years.

Massage Information

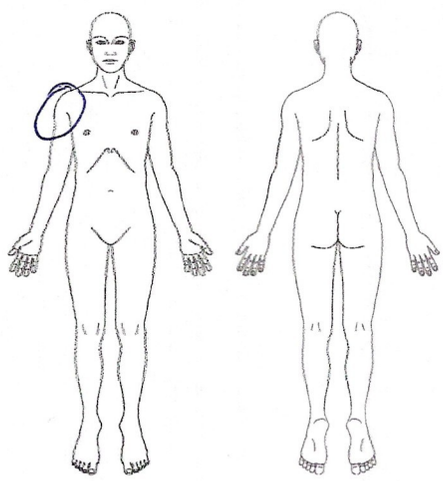
Have you had professional massage before? ☐ yes ☒ no How recently? _____

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 FR Drysdale Date 18.2.25

Therapist Signature _____ Date 18/2/25