Massage Intake Form

Personal Information

Name Marjory Drummond Phone (day) 0413453635 (evening) 0413453635

Address 502 Cinema Goorianawarra Rd. City/State/Zip Bugaldie 2357 DOB 28/12/1967

Occupation Teacher Employer NSW DOE

Email marjd@live.com.au Primary Physician Dr Siva.

Emergency Contact Rob McClashan Relationship partner Phone 0427431671

How did you hear about us? Facebook

Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use: Orange

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 Back pain

What makes it better? movement

What makes it worse? being stationary

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 _____

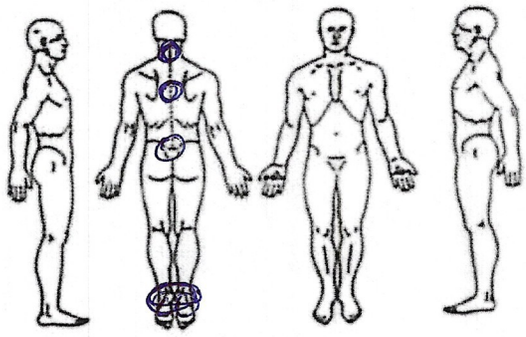
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

Please explain _____

What are your goals for this treatment session?

loosen up

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 _____ *Date* 2/7/24

Therapist Signature _____ *Date* _____