

Massage Intake Form

Personal Information

Name Ash Eveleigh Phone (day) _____ (evening) _____
Address 651 Kaputar Rd Nbn City/State/Zip NSW DOB 12/8/87
Occupation Photographer Employer Myself
Email _____ Primary Physician _____
Emergency Contact Michael Eveleigh Relationship Husband Phone 0429822772
How did you hear about us? _____

Medical Information

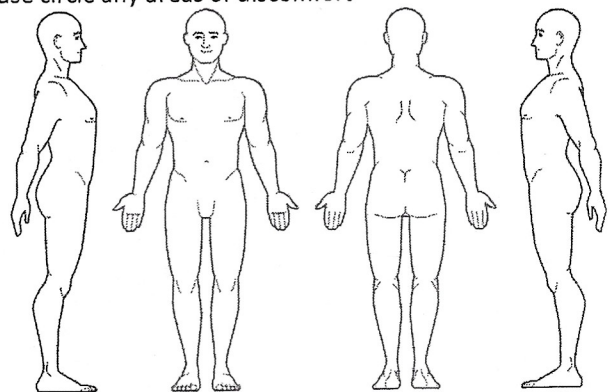
Are you taking any medications? ☒ yes ☒ no
If yes, please list name and use: Lexapro
Are you currently pregnant? ☐ yes ☒ no
If yes, how far along? _____
Any high risk factors? _____
Do you suffer from chronic pain? ☐ yes ☒ no
If yes, please explain _____
What makes it better? _____
What makes it worse? _____
Have you had any orthopedic injuries? ☐ yes ☒ no
If yes, please list: _____
Please indicate any of the following that apply to you.

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> 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 Bee Stings / Prawns
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?
Knots in neck + shoulders
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 [Signature] Date 6/10/23
Therapist Signature [Signature] Date 6/10/23

[Signature]

25/3/25