Massage Intake Form

Personal Information

Name NAOMI HARDY Phone (day) 0400267690 (evening) ______

Address 5/31 Doyle St City/State/Zip NARRARRI N.S.W DOB 16-1-60

Occupation ______ Employer ______

Email ______ Primary Physician DR. NAVIN

Emergency Contact Sam Manton Relationship Daughter Phone 0439746813

How did you hear about us? FRIEND

Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use: Blood pressure

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 knee neck BACK

What makes it better? HOT PAC WALKING

What makes it worse? ______

Have you had any orthopedic injuries? ☑ yes ☐ no

If yes, please list: Broken Fem

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:

Osto

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 ______

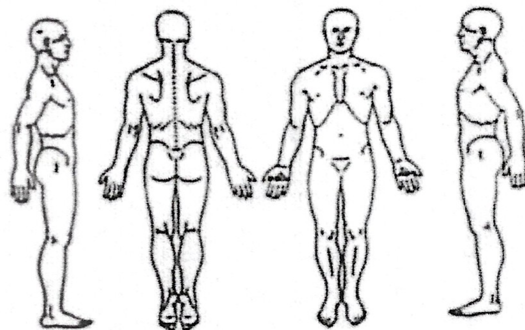
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain ______

What are your goals for this treatment session?

______

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 NHardy *Date* ______

Therapist Signature ______ *Date* ______