

Client Intake Form - Therapeutic Massage

Client Information

Name Kellie Hardy Email noble.k@live.com.au
 Phone (cell/day) 0402 269 675 DOB 19.7.1970 Age: 54
 Address 34 Cormie Ave. City/State/Zip Weewaa NSW 2388
 Emergency Contact Name Mick Hardy Phone 0438401037 Relationship Husband
 Occupation Program Manager Referred by: Fresia sight

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: _____

Areas of swelling	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Diabetes	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Osteoporosis	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>
Autoimmune disorder	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Fibromyalgia	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Phlebitis	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>
Back / neck problems	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Headaches	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Sciatica	yes <input checked="" type="checkbox"/> no <input type="checkbox"/>
Bleeding disorders	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Heart condition	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Seizures	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>
Blood clots	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Hypertension	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Stroke	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>
Bruise easily	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Kidney disease	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Tendinitis	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>
Bursitis	yes <input checked="" type="checkbox"/> no <input type="checkbox"/>	Multiple sclerosis	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	TMJ disorder	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>
Cancer	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Neurological condition	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Varicose veins	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>
Contagious condition	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Neuropathy	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Vertigo / dizziness	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>
Decreased sensation	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>	Osteoarthritis	yes <input type="checkbox"/> no <input checked="" type="checkbox"/>		

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: _____

Please describe any other injuries or health conditions: (R) hip - / lower back - pain / muscle
Sciatica - symptoms

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 Kellie Hardy Date 30/10/24

Therapist Signature _____ Date _____

