Massage Intake Form

Personal Information

Name Kathryn Hamilton Phone (day) 0428652124 (evening) _____

Address 2920 Killarney Gap Rd City/State/Zip Narrabri 2390 DOB _____

Occupation Retired Employer _____

Email khwestend@gmail.com Primary Physician Dr Sumudu

Emergency Contact Richard Hamilton Relationship Son Phone 0438

How did you hear about us? Word of mouth

Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use: see over

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 Sciatic nerve

What makes it better? exercise to a degree

What makes it worse? sitting or lying down

Have you had any orthopedic injuries? ☑ yes ☐ no

If yes, please list: Fractured pelvis, broken arm, broken hand bones knee replacement

Please indicate any of the following that apply to you.

- ☑ Cancer breast
- ☐ 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:

osteo arthritis through body x 2 both knees full replacement L4 & L5 to clear sciatica

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 _____

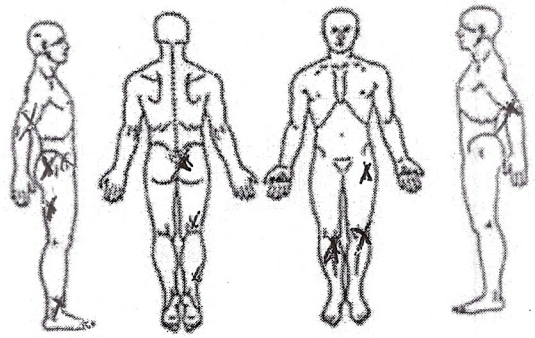
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

Please explain _____

What are your goals for this treatment session?

To control nerve pain in lower leg

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 KHHamilton *Date* 16/10

Therapist Signature _____ *Date* 16/10/24