

Massage Intake Form

Personal Information

Name Richard Hamilton Phone (day) 0437873151 (evening) _____
Address West End, 2920 City/State/Zip Narrabri DOB 14/9/65
Occupation Farmer Employer Self
Email rhduke@gmail.com Primary Physician _____
Emergency Contact 0428652124 Relationship _____ Phone _____
How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☒ no
If yes, please list name and use: _____

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: Leg, Shoulder, rib breaks

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 _____

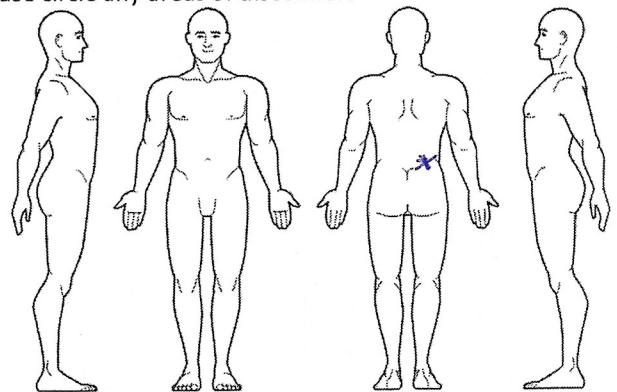
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

Please explain _____

What are your goals for this treatment session?

relieve back pain

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 Richard Hamilton Date 2/8/23

Therapist Signature _____ Date _____