Massage Intake Form

Personal Information

Name Lisa Hayne Phone (day) 0439447556 (evening) _____

Address 9 Guest St City/State/Zip Narrabri DOB 28/3/86

Occupation Paramedic Employer _____

Email lhayne@y7mail.com Primary Physician Dr Rohana

Emergency Contact Tim Hayne Relationship Husband Phone 0491942147

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: _____

Please indicate any of the following that apply to you.

☐ Cancer	☐ Fibromyalgia
☐ Headaches/Migraines	☐ Stroke
☒ Arthritis	☐ Heart Attack
☐ Diabetes	☐ Kidney Dysfunction
☐ Joint Replacement(s)	☐ Blood Clots
☐ High/Low Blood Pressure	☐ Numbness
☐ Neuropathy	☐ Sprains or Strains

Explain any conditions you have marked above:

Both knees.

_____

_____

_____

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 _____

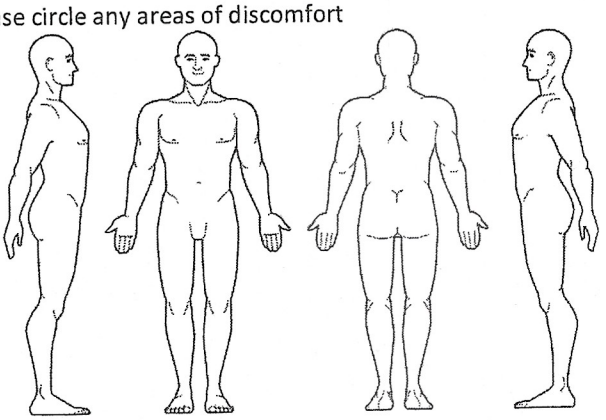
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

Please explain _____

What are your goals for this treatment session?

Relax & target tension in 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 _____ *Date* 25/5/24

Therapist Signature _____ *Date* 25/5/24