Massage Intake Form

Personal Information

Name Charlotte Jaulian Phone (day) 0431649041 (evening) " "

Address 1305 West Pont Rd Nkrabi City/State/Zip NSW DOB 26/03/94

Occupation Student Employer

Email charlotte.Jaulian@gmail.com Primary Physician Dr Ojah

Emergency Contact bn Duffy Relationship Grandfather Phone 67923117

How did you hear about us? In person

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
- ☑ 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:

Massage Information

Have you had a professional massage before? ☑ yes ☐ no

What type of massage are you seeking?

☑ Relaxation ☑ Therapeutic/Deep Tissue

Other shiatsu

What pressure do you prefer?

☐ Light ☐ Medium ☑ Deep

Do you have any allergies or sensitivities? ☑ yes ☐ no

Please explain Penicillin, soy

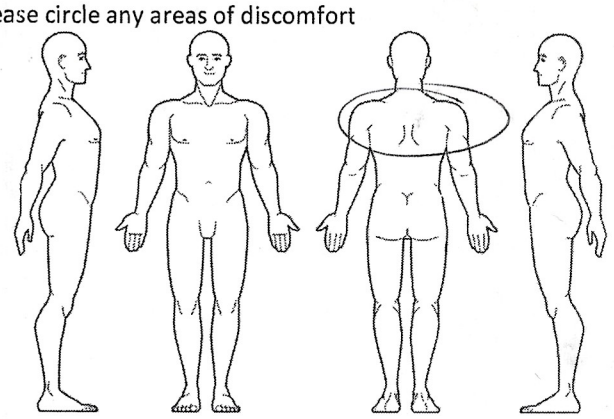
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☑ yes ☐ no

Please explain face

What are your goals for this treatment session?

relaxation

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 [signature] *Date* 07 July

Therapist Signature *Date*