

# Client Intake Form - Therapeutic Massage

## Client Information

Name Julie Jones Email juliejones94@yahoo.com  
 Phone (cell/day) 8405705504 DOB 5/2/72 Age: 32  
 Address 15 Wilga St Bellata City/State/Zip 2397  
 Emergency Contact Name mark jones Phone 0428856229 Relationship \_\_\_\_\_  
 Occupation \_\_\_\_\_ Referred by: \_\_\_\_\_

## Health Information

Are you taking any medications? ☒ yes ☐ no If yes, please list: epilm, thyroxin  
 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 type="checkbox"/> no <input checked="" 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 checked="" type="checkbox"/> no <input 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 type="checkbox"/> no <input checked="" 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 checked="" type="checkbox"/> no <input 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 checked="" type="checkbox"/> no <input 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: Fractured Skull, Jaw, nose, Ankle  
 Please describe any other injuries or health conditions: epilepsi, thyroid

## 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 \_\_\_\_\_ Date 14/12/24  
 Therapist Signature \_\_\_\_\_ Date 14/12/24

