# Massage Intake Form

## Personal Information

Name Shaun Kerr Phone (day) 0438685091 (evening) Same

Address 79 Peele Street City/State/Zip Narrabri N.S.W 2390 DOB 17/3/1987

Occupation Teacher's Aid Employer St. Francis Narrabri

Email shaun.kem.87@hotmail.com Primary Physician Dr Ojah

Emergency Contact 0429 842 999 Robert Kerr Relationship Dad Phone

How did you hear about us?

## Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use: Norflex, Ramipril, Pregabalin, Amlodipine, Prazosin, Amitriptyline

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 C.R.P.S

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:

Hypotension
Complex Regional Pain Syndrome
left side High ligation Varicocele
Renal denervation
Spinal Cord Stimulator

## 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

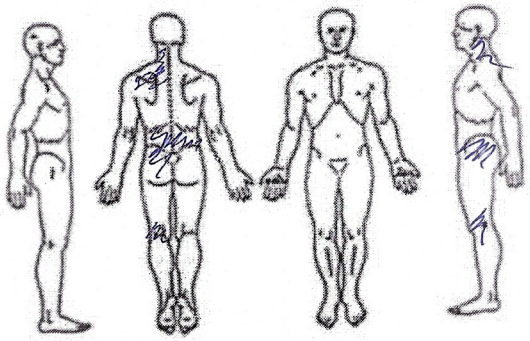
Please explain

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?

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* 24/5/24

*Therapist Signature* [signature] *Date*