Massage Intake Form

Personal Information

Name Kate Lennon Phone (day) 0408 163 477 (evening) _____

Address 195 Carrigan Rd City/State/Zip Meran North DOB 6.10.74

Occupation farming Employer self

Email katelattin@hotmail.com Primary Physician Dr Siva.

Emergency Contact Nick Relationship husband Phone 0409 031 930

How did you hear about us? Herb & Spice

Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use: thyroxine 25mcg daily

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? Driving

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: Past food

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☑ Headaches/Migraines
- ☑ Arthritis lower back
- ☐ 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 _____

What pressure do you prefer?

☐ Light ☑ Medium ☐ Deep

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

Please explain _____

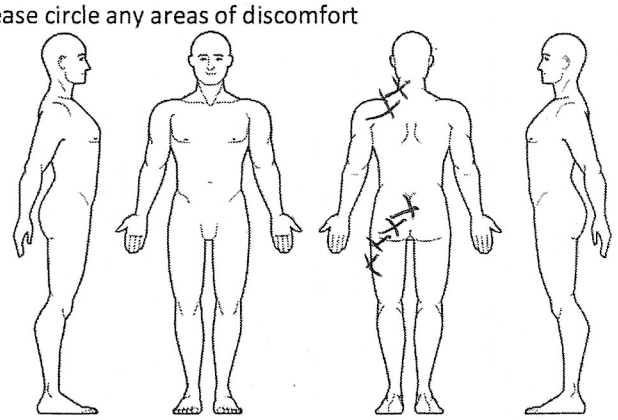
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

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 Kate Lennon *Date* _____

Therapist Signature _____ *Date* _____

KL. 5/6/24.