Massage Intake Form

Personal Information

Name Rowan McClung Phone (day) 0428392503 (evening) _____

Address 16346 Kamilaroi Hwy City/State/Zip Baan Baa, NSW, 2390 DOB 19/1/86

Occupation Underground Electrician Employer Whitehaven

Email r.r.mcclung@hotmail.com Primary Physician _____

Emergency Contact Ellen McClung Relationship Wife. Phone _____

How did you hear about us? Wife.

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:

Lower back strain.

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 _____

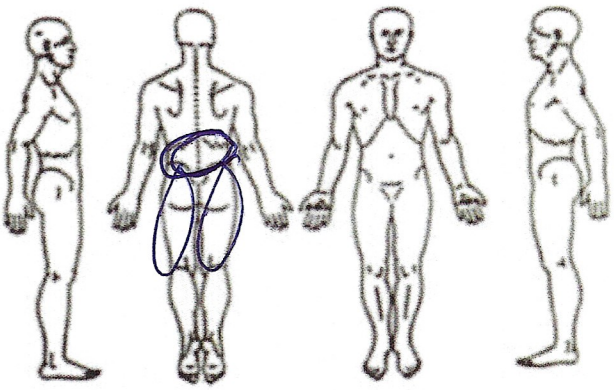
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

Please explain _____

What are your goals for this treatment session?

Pain relief.

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* 21/8/24

Therapist Signature _____ *Date* 21/8/24