

# Massage Intake Form

## Personal Information

Name Katrina Panter Phone (day) 0429 984785 (evening) \_\_\_\_\_  
Address 21922 Kamilari Hwy City/State/Zip Narrabri DOB 21-10-1997  
Occupation HST manager Employer UTC  
Email Katrina.panter@outlook.com Primary Physician \_\_\_\_\_  
Emergency Contact Tom Gray Relationship Partner Phone 0409 029480  
How did you hear about us? Insta

## 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.

- |  |   |
|--|---|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Fibromyalgia       |
| <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots        |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Neuropathy              | <input type="checkbox"/> 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

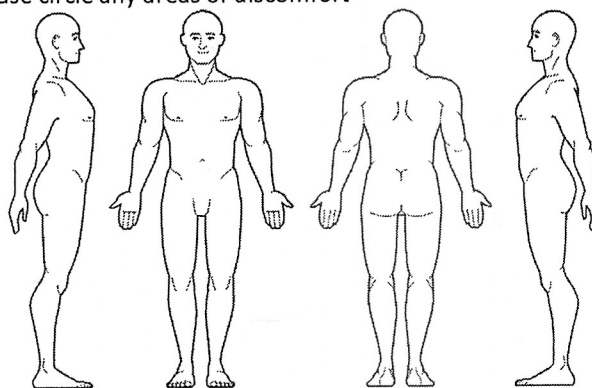
Please explain \_\_\_\_\_

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 [Signature] Date 20-08-23

Therapist Signature [Signature] Date 29/3/23