

Massage Intake Form

Personal Information

Name Ellen McClung Phone (day) 0429949038 (evening) _____
Address 16346 Kamilaroi Hwy City/State/Zip Baan Baan DOB 28/11/87
Occupation Mum Employer _____
Email elli54490@gmail.com Primary Physician Dr Navin Erathnidge
Emergency Contact Rowan Relationship Husband Phone 0428392503
How did you hear about us? _____

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: dislocated shoulders

Please indicate any of the following that apply to you.

- | | |
|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input checked="" 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

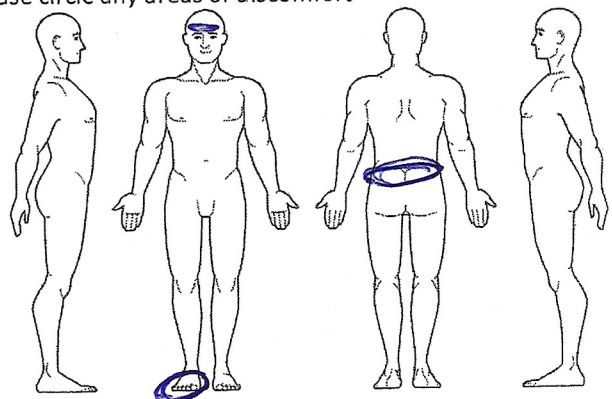
Please explain _____

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 16/11/23

Therapist Signature [Signature] Date 16/11/23

[Signature] 20/7/24.