

Massage Intake Form

Personal Information

Name Paige Merten Phone (day) 0484923388 (evening) N/A
Address 168 Jacks Creek Rd City/State/Zip NSW 2370 DOB 18/08/1998
Narrabri
Occupation N/A Employer N/A
Email pa.gemaciers@gmail.com Primary Physician _____
Emergency Contact Drew Relationship Husband Phone 0400802855
How did you hear about us? Online

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.

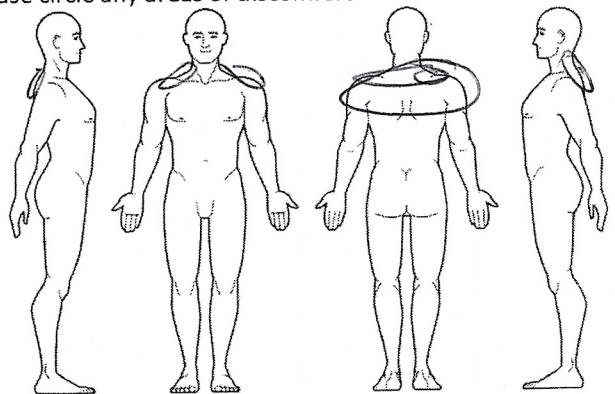
- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> 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 Paige Merten Date 10/5/24

Therapist Signature [Signature] Date 10/5/24