

# Massage Intake Form

## Personal Information

Name Rebecca Verrier Phone (day) 0400597939 (evening) \_\_\_\_\_  
Address 29 Walowa City/State/Zip Narrabri DOB 15/6/93  
Occupation Teacher's aide Employer ST Francis Xavier  
Email becca-boo-live@hotmail Primary Physician DR Ojan  
Emergency Contact Sue Cameron Relationship Mum Phone 0447230794  
How did you hear about us? Facebook

## 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 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:

tension headaches.

## 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 Gluten, Dairy, Soy, Corn

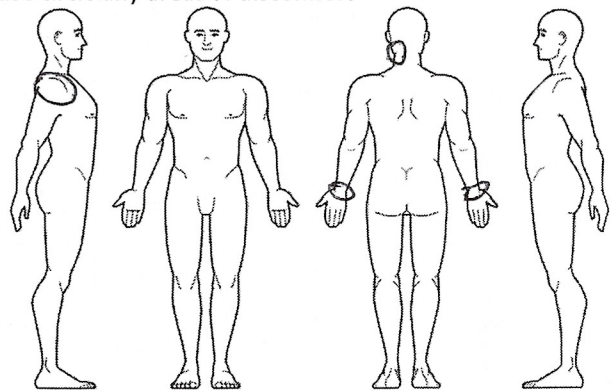
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

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

What are your goals for this treatment session?

To relax

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 4/7/23

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_