

Massage Intake Form

Personal Information

Name Kait Whiting Phone (day) 0448509608 (evening) _____
 Address 13 Lenore St City/State/Zip Narrabri DOB 01.05.29
 Occupation Club manger Employer Anytime Fitness
 Email Kait-Jones 313@hotmail Primary Physician _____
 Emergency Contact Grant Relationship Husband Phone 0417 677310
 How did you hear about us? _____

Medical Information

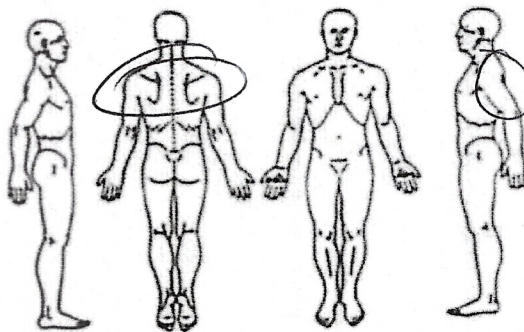
Are you taking any medications? ☒ yes ☐ no
 If yes, please list name and use: duloxetine
30mg
 Are you currently pregnant? ☐ yes ☒ no
 If yes, how far along? _____
 Any high risk factors? _____
 Do you suffer from chronic pain? ☐ yes ☒ no
 If yes, please explain _____
 What makes it better? _____
 What 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?
pressure release / knots
 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 28/5/24

Therapist Signature _____ Date _____