Massage Intake Form

Personal Information

Name Caitlin Taylor Phone (day) 0411213162 (evening) _____

Address 27 Warrior St City/State/Zip Wee Waa DOB 04/02/91

Occupation Teacher Employer DOE

Email caitlin.taylor4@hotmail.com Primary Physician Dr Siva

Emergency Contact Scott Hardy Relationship Fiancé Phone 0402 851 814

How did you hear about us? Text

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: Dislocations Knee Ribs SI Joint

Please indicate any of the following that apply to you.

☐ Cancer	☐ Fibromyalgia
☒ Headaches/Migraines	☐ Stroke
☐ Arthritis	☐ Heart Attack
☐ Diabetes	☐ Kidney Dysfunction
☐ Joint Replacement(s)	☐ Blood Clots
☐ High/Low Blood Pressure	☐ Numbness
☐ Neuropathy	☐ 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 Strawberry Scents

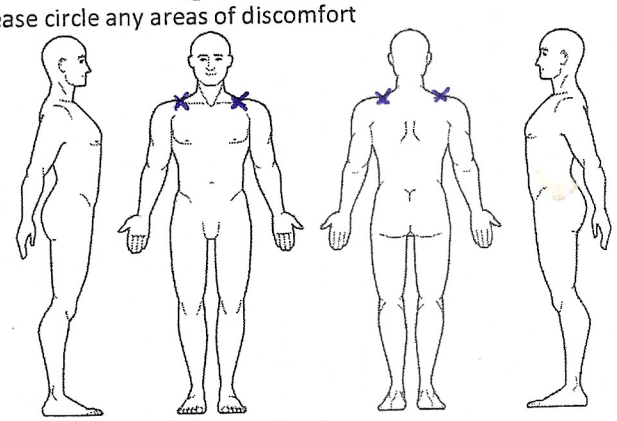
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

Please explain _____

What are your goals for this treatment session?

Removing tension from neck

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 _____ *Date* 11.10.23

Therapist Signature _____ *Date* 11.10.23