Massage Intake Form

Personal Information

Name Alison Thomas Phone (day) _____ (evening) _____

Address 14412 Newell Hwy City/State/Zip Edgeroi DOB 07/04/97

Occupation Vet Employer _____

Email alison.thomas365@gmail.com.au Primary Physician _____

Emergency Contact Ben Guest Relationship Partner Phone _____

How did you hear about us? Google

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.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

N/A.

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 _____

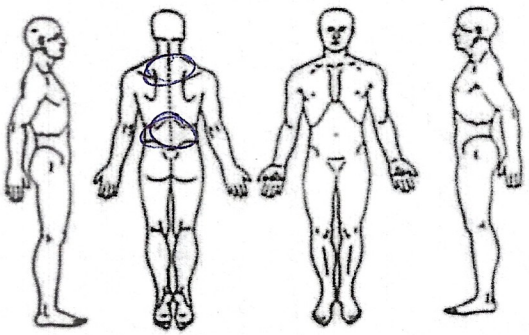
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

Please explain _____

What are your goals for this treatment session?

lower back release & relaxation

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* 5/7/24

Therapist Signature _____ *Date* 5/7/24