

Massage Intake Form

Personal Information

Name Kaitlyn Storey Phone (day) 0439 607572 (evening) _____
Address 10 Jenkins St City/State/Zip Narrabri, NSW, 2390 DOB 24/03/01
Occupation Education Support officer Employer CVC NW
Email kaitlyn2001@hotmail.com.au Primary Physician _____
Emergency Contact Zoe Tomunson Relationship partner Phone 0487 841693
How did you hear about us? _____

Medical Information

Are you taking any medications? ☒ yes ☐ no
If yes, please list name and use: Duloxetine
progesterone
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 _____

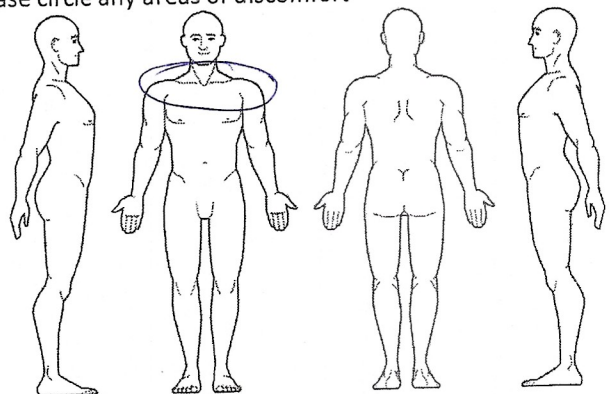
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

Please explain _____

What are your goals for this treatment session?

to release tension

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

18/10/23

Therapist Signature _____

Date _____