Massage Intake Form

Personal Information

Name Matthew Pussell Phone (day) 0459 477 479 (evening) 0459 477 479

Address 11-35 Tiberuna, Narrabri City/State/Zip _____ DOB 12.10.1983

Occupation Surveyor Employer Pacific Survey, Port Mac Quarrie

Email pussgolf@hotmail.com. Primary Physician 0457 296 968

Emergency Contact Jess Sour 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:

_____

_____

_____

_____

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 _____

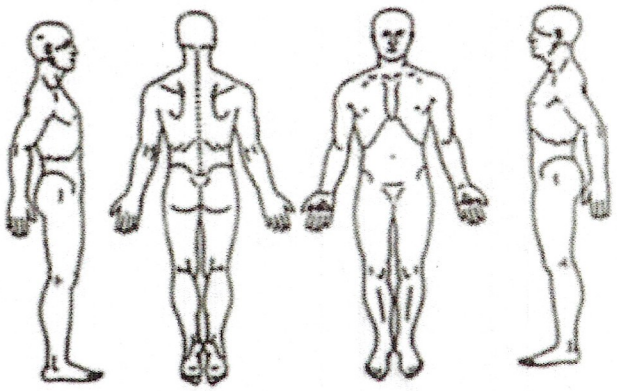
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☒ no

Please explain _____

What are your goals for this treatment session?

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 _____ *Date* 6.8.24.

Therapist Signature _____ *Date* 6/8/24.