Massage Intake Form

Personal Information

Name MARGARET RICKWOOD Phone (day) 0418 477 144 (evening) _____

Address 20 O'MALLEY CLOSE City/State/Zip GRAFTON 2460 DOB 30-10-50

Occupation RETIRED Employer _____

Email margierickwood@hotmail.com Primary Physician DR ACHINI

Emergency Contact 040706 4506 Relationship HUSBAND Phone _____

How did you hear about us? GOOGLE

Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use: _____

RIVOTRIL, ARROPAX

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: S1 L5 - DISTECTOMY.

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 _____

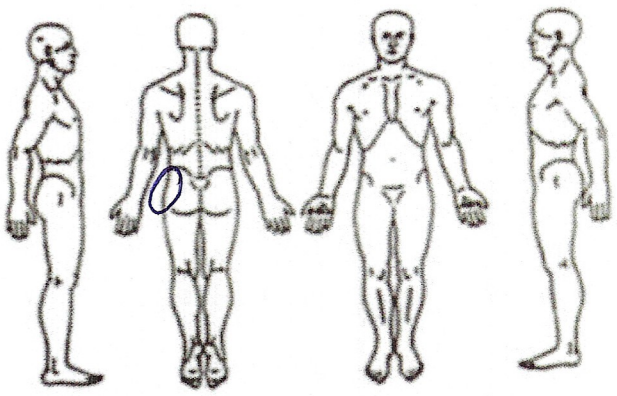
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☑ no

Please explain _____

What are your goals for this treatment session?

FREE OF PAIN.

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 M Rickwood *Date* 12-10-2024

Therapist Signature _____ *Date* 12-10-24