Client Intake Form - Therapeutic Massage

Client Information

Name STEPHEN REX Email SSEXYREXY@GMAIL.COM

Phone (cell/day) 0409907741 DOB 11.3.61 Age: 63

Address 32 BURIAL ST City/State/Zip NARRABRI

Emergency Contact Name 0429907741 CHRIS REX Phone _____ Relationship WIFE

Occupation FACILITY OFFICER Referred by: _____

Health Information

Are you taking any medications? ☑ yes ☐ no If yes, please list: MICARDIS

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☑ no If yes, please list: _____

Are you pregnant? ☐ yes ☑ no If yes, how many months: _____ Due date: _____

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☑ no

If yes, please describe: _____

Areas of swelling	yes (no)	Diabetes	yes (no)	Osteoporosis	yes (no)
Autoimmune disorder	yes (no)	Fibromyalgia	yes (no)	Phlebitis	yes (no)
Back / neck problems	(yes) no	Headaches	yes (no)	Sciatica	(yes) no
Bleeding disorders	yes (no)	Heart condition	yes (no)	Seizures	yes (no)
Blood clots	yes (no)	Hypertension	yes (no)	Stroke	yes (no)
Bruise easily	yes (no)	Kidney disease	yes (no)	Tendinitis	(yes) no
Bursitis	yes (no)	Multiple sclerosis	yes (no)	TMJ disorder	yes (no)
Cancer	yes (no)	Neurological condition	yes (no)	Varicose veins	yes (no)
Contagious condition	yes (no)	Neuropathy	yes (no)	Vertigo / dizziness	yes (no)
Decreased sensation	yes (no)	Osteoarthritis	yes (no)		

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☑ no If yes, where? _____

History of joint replacement surgery? ☐ yes ☑ no Which joint(s) ? _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☑ no Please describe: _____

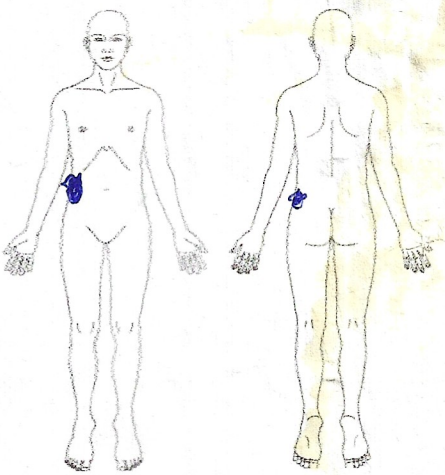
Please describe any other injuries or health conditions: LOWER BACK FUSED & SPINAL STIMULATOR FITED

Massage Information

Have you had professional massage before? ☑ yes ☐ no How recently? 1 YEAR

Reason for seeking massage: ☐ Relaxation ☑ Specific problem

Please indicate any areas of discomfort



How much pressure do you prefer? ☐ Light ☐ Medium ☑ Firm

By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature _____ Date 30.10.24

Therapist Signature _____ Date 30.10.24.