

# Client Intake Form - Therapeutic Massage

## Client Information

Name ALAN MARSHALL Email alan.marshall@qnet.com  
 Phone (cell/day) 0402 202 761 DOB 15/02/66 Age: 58  
 Address 17 WALCOWA ST City/State/Zip \_\_\_\_\_  
 Emergency Contact Name DAMON MARSHALL Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 Occupation SON Referred by: \_\_\_\_\_

## Health Information

Are you taking any medications? ☐ yes ☒ no If yes, please list: \_\_\_\_\_  
 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 currently under medical supervision or receiving other medical interventions? ☐ yes ☒ no  
 If yes, please describe: \_\_\_\_\_

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

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☒ no If yes, where? \_\_\_\_\_  
 History of joint replacement surgery? ☒ yes ☐ no Which joint(s)? R. KNEE  
 Recent injuries or medical procedures in the past 2 years? ☐ yes ☒ no Please describe: \_\_\_\_\_  
 Please describe any other injuries or health conditions: \_\_\_\_\_

## Massage Information

Have you had professional massage before? ☒ yes ☐ no How recently? 8 mths

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 [Signature] Date 26/10/24

Therapist Signature [Signature] Date 26/10/24

