Massage Intake Form

Personal Information

Name Adam McCredie Phone (day) 0427817464 (evening) _____

Address Girraween Kayata Rd City/State/Zip Narrabri DOB _____

Occupation Gardn / Contractor Employer Self.

Email blueteng lizard@ live.com.au Primary Physician Dr Rehema

Emergency Contact 0427C. McCredie Relationship Father Phone 0427935575

How did you hear about us? _____

Medical Information

Are you taking any medications? ☑ yes ☐ no

If yes, please list name and use: Atacand

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:

Carpel tunnel Surgery 20 years ago.

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 Food intolerances.

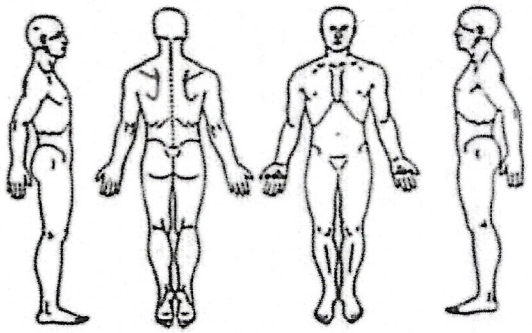
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort All over.



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 Adam McCredie *Date* 25/6/24

Therapist Signature _____ *Date* 25/6/24.