



MASSAGE &  
LYMPHATIC DRAINAGE  
ELTHAM

*Michelle Raines*

## MASSAGE & LYMPHATIC DRAINAGE ELTHAM

# CLIENT INTAKE

Name Michelle Raines Age 62  
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### MEDICAL HISTORY

Please tick if you have any of the following symptoms or conditions (past or present);

#### GENERAL

- ☐ Allergies
- ☒ Cancer
- ☐ Diabetes
- ☐ Fatigue / CFS
- ☐ Headaches / Migraines
- ☐ HIV
- ☐ Infectious Condition
- ☐ Kidney Problems
- ☐ Stress
- ☐ Vision Problems
- ☐ Hearing Impairment

#### RESPIRATORY

- ☐ Asthma / Lung Issues
- ☐ Difficulty Breathing
- ☐ Cold / Flu
- ☒ Sinusitis / Sinus Issues

#### REPRODUCTIVE

- ☒ Menopause
- ☐ Perimenopause
- ☐ Painful Menstruation
- ☐ Pregnant

#### SKIN CONDITIONS

- ☐ Eczema
- ☐ Fungal Infection
- ☐ Skin Infection
- ☐ Psoriasis
- ☐ Rash

#### DIGESTIVE

- ☐ Abdominal Pain
- ☒ Constipation
- ☐ Diarrhoea
- ☐ Digestive Disorder
- ☐ Irritable Bowel

#### MUSCULOSKELETAL

- ☒ Arthritis
- ☐ Carpal Tunnel Syndrome
- ☐ Jaw Pain / TMJ
- ☐ Joint Pain
- ☐ Joint Injury
- ☐ Joint Replacement
- ☐ Muscle Pain
- ☐ Muscle Injury
- ☒ Osteoporosis

#### CARDIOVASCULAR

- ☐ Blood Clots
- ☐ Heart Issues
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☒ Swollen Ankles
- ☒ Fluid Retention
- ☐ Varicose Veins
- ☐ Other

#### NERVOUS SYSTEM

- ☐ Depression
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Menieres
- ☐ Numbness
- ☐ Sciatica
- ☒ Sleep Difficulties
- ☐ Tingling
- ☐ Other

# CLIENT INTAKE

If you have selected any issues above, please provide details;

Start 2014

Left shin - Lungs + Liver

2017

## MASSAGE & LYMPHATIC DRAINAGE ELTHAM

# CLIENT INTAKE

Have you had a professional massage before?

Y ☒ N ☐

Do you have difficulty lying on your front, back or side?

☐ ☒

Do you have allergies to oils, creams, lotions or ointments?

☐ ☒

Do you have sensitive skin?

☐ ☒

Are there any areas (ie feet, face) you do not want massaged?

☐ ☒

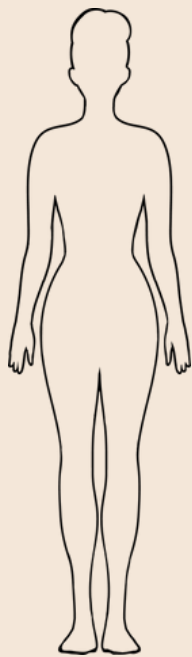
What type of massage are you seeking? ☐ Relaxation ☒ MLD ☒ Remedial

What pressure range do you prefer? ☐ Light-Medium ☐ Medium-Firm

*Mark any specific areas you would like your therapist to concentrate on:*



*Front*



*Back*



*Right*



*Left*

Please provide details;

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# MASSAGE & LYMPHATIC DRAINAGE ELTHAM

## CONSENT FORM

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*Client's Name*


I have to the best of my knowledge, provided all relevant information about my health and medical history and I give my full consent to treatment.

I intend this consent to apply to all future treatments and I understand that I must update my service provider with any changes that may occur in my medical history.

I understand that a 50% cancellation fee may apply if I do not provide a minimum of 24 hours notice.

*My signature acknowledges that I have read and agree to receive the massage therapy and that I will adhere to all of the aforementioned statements.*

Michelle Raines            2.7.25  
*Client Name*                      *Client Signature*                      *Date*

Tani Gray            2.7.25  
*Therapist Name*                      *Therapist Signature*                      *Date*