JANE GUY
massage therapist

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Massage & Myotherapy Australia Member ABN 62 431 190 929

Massage Client Intake Form

CONFIDENTIAL

Welcome! I would like to make your appointment as pleasant and as comfortable as possible. If at any time you have questions regarding your session, please let me know.

Personal Information

Last name:		First name:	
Date of Birth:	Gender: M *(circle)* F	Email:	
Address:			
Suburb:		City:	Post Code:
Home/Mobile Phone Number:			
Occupation:			
General Practitioner:		Phone Number:	

Massage History and Treatment Information

When was your last massage? _____

How frequently do you get a massage? _____

What type of pressure do you like? Deep _____ Medium _____ Light _____ Depends _____

Your main reason for a massage today? Relaxation/Stress reduction_____ Pain relief_____

Soreness from exercise _____ Holistic/Emotional/Psychological work _____ Other _____

In a full body massage I generally work on your back, shoulders, upper buttocks, legs, feet, arms, hands, neck, scalp and face. I do not massage the stomach unless requested. All areas of your body will be properly draped. Please let me know if there is any area of your body that you prefer not to receive massage.

Health History

Do you have any chronic, ongoing pain that you deal with on a regular basis? Yes _____ No _____

Please explain: _____

What activities cause this pain/make it worse: _____

Please list all current medications: _____

Do you have allergic reactions to any oils, lotions etc applied to your skin? Yes _____ No_____

Please explain: _____

Please turn over ➡

Health History *(continued)*

Please mark any condition(s) that apply/have applied to you:

current fever ☐
headaches ☐
migraines ☐
diabetes ☐
infectious diseases ☐
hernia ☐
cancers/tumors ☐
seizures ☐
athletes foot ☐
skin/nail conditions ☐
allergies ☐
numbness/tingling ☐
whiplash ☐
cold feet or hands ☐
problems walking ☐
orthotics ☐

CARDIOVASCULAR
heart attack ☐
stroke ☐
blood clots ☐
varicose veins ☐
high/low blood pressure ☐

GASTROINTESTINAL
nausea, vomiting ☐
diarrhea, IBS ☐
digestive problems ☐
persistent abdominal pain ☐

RESPIRATORY
persistent cough ☐
asthma/lung conditions ☐

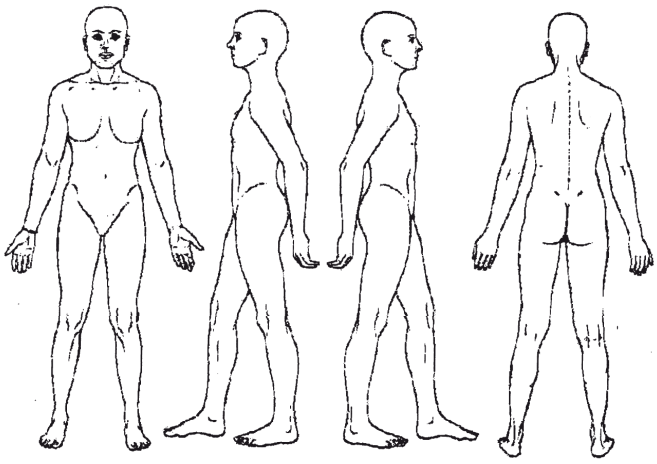
MUSCULOSKELETAL
broken/fractured bones ☐
osteoporosis ☐
scoliosis ☐
disc problems ☐
arthritis ☐
muscle/tendon injuries ☐

OTHER
please describe ☐

Women: Pregnant? No____ Yes____ Due Date: _____

Please indicate with a cross (X) the location of any pain.

(Notes if required:) _____



Payment, Cancellation Policy and Client Informed Consent

- Full Payment is due at the time of service unless prior arrangements have been made.
- You will be charged the full fee for a cancellation made **within 24 hours** of your scheduled appointment. The charge for late cancellation can be waived if your original appointment can be re-scheduled to another day in the same week. Exceptions for late cancellations may be made for extraordinary circumstances.

As a client, I understand that massage therapy is not a replacement for medical care and that no diagnosis will be made. I have informed the massage therapist of all my known physical and medical conditions and medications. I will keep the massage therapist updated on any changes. I freely give my consent for the therapy received. I understand that clients under the age of 18 must have the consent of a parent/guardian, and be accompanied by a parent/guardian for the entire session.

Client /Parent/Guardian signature | *Therapist signature* | *Date*