

Healthy Kneads Massage Therapy

Client Intake Form

Please complete this form as best as you can. Please print clearly.

Last Name _____ First Name _____

Address _____

_____ Postcode _____

Date of Birth ____/____/____

Email Address _____

Telephone Number _____ (H) _____ (W) _____ (M)

Occupation _____

Referred by _____

Recreational activities _____

Reason for visit _____

How did you first hear about us? _____

Have you had a massage before? _____

Do you experience any difficulty lying on your front? _____

Do you experience any difficulty lying on your back? _____

Please tick all conditions that you suffer, or have suffered from.

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscle or bone injuries |
| <input type="checkbox"/> High / low blood pressure | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Muscle or joint pain |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Cancer / tumours | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Asthma / lung conditions | <input type="checkbox"/> Headaches or migraines |
| <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Arthritis | |

Other medical conditions or injuries not listed (past and present)

Known allergies _____

Current prescribed medications _____

Recent surgeries _____

Do you smoke? _____

Signed _____ Date _____