Client Intake Form

Personal Information

Name..... Date of Birth.....
Address..... Suburb.....
Postcode..... Mobile.....

Sex M / F / Other Email.....

Health Information (Please tick all that apply)

- ❑ Smoker
- ❑ Sunburn
- ❑ Headache
- ❑ Asthma
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Depression
- ❑ Hemophilia
- ❑ Cuts, Burns, Bruises
- ❑ Severe Pain
- ❑ Arteriosclerosis
- ❑ Varicose Veins
- ❑ Blood Colts / DVT
- ❑ Dizziness
- ❑ Back Pain /Sciatica
- ❑ Constipation / Diarrhea
- ❑ Allergies
- ❑ Recent Surgery
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Inflammation
- ❑ Pregnant
- ❑ Hernia
- ❑ Musculoskeletal Problem
- ❑ Tuberculosis
- ❑ Cancer
- ❑ Rashes
- ❑ Cold / Flu
- ❑ Arthritis
- ❑ Stomach Problems
- ❑ Pacemakers / Pins
- ❑ Heart Disease
- ❑ HIV
- ❑ Athletes Foot
- ❑ Contact Lenses
- ❑ Visually and / or Hearing Impaired

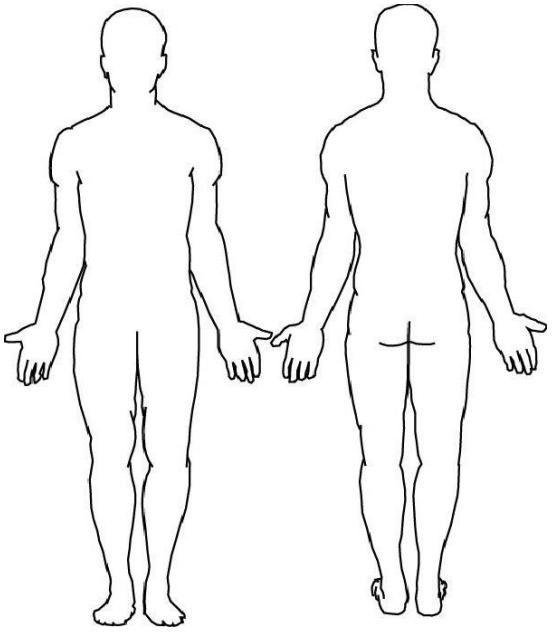
Advise of any other health issues we should know about
.....
.....
.....

List any medications you are on
.....
.....
.....

Is this your first massage ❑ Yes ❑ No
Is there any part of your body that you do not like to be touched or massaged?
.....
.....

What is the primary purpose of your visit today?
❑ Relaxation ❑ Pain Relief ❑ Therapeutic ❑ Other.....

Please mark the areas of discomfort



Consent of treatment

I understand that massage practitioners do not diagnose illness, diseases or any physical or mental disorders, nor do they prescribe medical treatments or perform spinal manipulations. I acknowledge that a massage is not a substitute for a medical examination or diagnosis and it is recommended that I see a primary health care provider for that service.

I have stated all known medical conditions and will take responsibility for alerting my therapist of any changes to my health status, medications and therapies before the session. I will advise the therapist of any perceived chances resulting from my massage therapy as soon as I become aware of them.

I understand that no sexual activities, comments or innuendo will be tolerated. The therapist reserves the right to refuse services at their discretion based upon the clients' conditions, therapist's skill set, client's attitude or action etc. without explanation or prior notice and I agree to this policy.

24 hours notice is required if you wish to change or cancel your scheduled appointment. A 100% charge will apply for any treatments cancelled with less than 24 hours notice. This also applies for no show clients.

Date.....Signature.....