ML Massage Therapy - ABN 77101024931 Monika Lewis Bluffpoint
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CONFIDENTIAL CLIENT HISTORY/INTAKE FORM

CONTACT AND PERSONAL DETAILS:

Given Name:		Surname:	
Address:			
Suburb:		Postcode:	
Home phone:		Mobile:	
email-address:			
Date of birth:		Occupation:	
Marital status:		Sports:	
Gender:	F / M	Pregnancy?	
Healthfund:	Y / N	Name	

EMERGENCY CONTACT DETAILS:

Full Name:	
Contact Number:	
Relationship:	

Please check and indicate conditions that apply to you:

Acute infectious disease ☐	Inflammation ☐	Aneurism ☐
Lymph-edema/Oedema ☐	Chronic fatigue ☐	Diabetes ☐
Low Blood pressure ☐	HIV Positive ☐	Cancer ☐
Hypertension/high Blood pr. ☐	Blood clots ☐	Arthritis ☐
Heart or Lunge disease ☐	Varicose veins ☐	Asthma ☐
Chronic respiratory disorder ☐	Contagious Infections ☐	Hepatitis ☐
Allergies to oils or fragrances ☐	Osteoporosis ☐	Epilepsy ☐
Phlebitis/thrombophlebitis ☐	Resent Injuries ☐	Hernia ☐
Embolus/pulmonary embolism ☐	Cardio-vascular cond. ☐	Skin Problems ☐
Stroke / myocardial infarct ☐	Headache/Migraine ☐	Mental Disease ☐

Further details: _____

_____

_____

Other _____

_____

Primary reason for getting massage:

Pain Relief ☐ Sports performance ☐ Recovery ☐ Relaxation ☐

Location of pain _____

For how long? _____

Have you seen a physician for this condition? If yes, what diagnosis?_____

_____

Are you currently under any medication? If yes please specify _____

_____

Prescribing physician? _____

How did you hear about me? _____

By signing below, I declare the information documented is accurate and complete. I have no physical restrictions, conditions or disabilities which would prevent me from receiving bodywork therapy.
I hereby give my consent to have the bodywork therapy performed on me.

Client
Signature_____Date____/____/_____

Please mark on the chart below with # of surgeries, scars, bruises or wounds. Also, place an “X” anywhere there is pain and circle “O” areas that are tight or need extra work.