

NZBMA Massage Intake Form Personal Information

Address	Name	Phone (c	day) (even	ing)	
Emergency Contact	Address	post cod	e	DOB	
Medical Information Massage Information Have you taking any medications? yes no If yes, please list name and use: What type of massage are you seeking? Body Mechanic Remedial/Deep Tissue What type of massage are you seeking? Body Mechanic Remedial/Deep Tissue What pressure do you prefer? Light Medium Deep Do you suffer from chronic pain? yes no If yes, please explain What makes it better? Are there any areas (feet, face, abdomen, etc.) you do not want massaged? yes no Please explain What are your goals for this treatment session? Please indicate any of the following that apply to you. Please indicate any of the following that apply to you. Cancer Fibromyalgia Headaches/Migraines Stroke Arthritis Heart Attack Diabetes Midney Dysfunction Joint Replacement(s) Blood Clots High/Low Blood Pressure Numbness Numbness	Occupation		Employer		
Medical Information Massage Information Have you taking any medications? yes no If yes, please list name and use: What type of massage are you seeking? Body Mechanic Remedial/Deep Tissue What type of massage are you seeking? Body Mechanic Remedial/Deep Tissue What pressure do you prefer? Light Medium Deep Do you suffer from chronic pain? yes no If yes, please explain What makes it better? Are there any areas (feet, face, abdomen, etc.) you do not want massaged? yes no Please explain What are your goals for this treatment session? Please indicate any of the following that apply to you. Please indicate any of the following that apply to you. Cancer Fibromyalgia Headaches/Migraines Stroke Arthritis Heart Attack Diabetes Midney Dysfunction Joint Replacement(s) Blood Clots High/Low Blood Pressure Numbness Numbness	Email	_			
Medical Information Are you taking any medications? yes no	_				
Are you taking any medications?	How did you hear about us?				
yes no What type of massage are you seeking? Body Mechanic Remedial/Deep Tissue	Medical Information		Massage Information		
Are you currently pregnant? yes no Body Mechanic Remedial/Deep Tissue					
Are you currently pregnant? yes no	ii yes, picase iist iiaine ana a	JC	What type of massage are you s	eeking?	
Any high risk factors? Do you suffer from chronic pain?	Are you currently pregnant?	□ yes □ no	☐ Body Mechanic	☐ Remedial/Deep Tissue	
Do you suffer from chronic pain?	If yes, how far along?		What pressure do you prefer?		
So you have any allergies or sensitivities? yes no	Any high risk factors?		☐ Light ☐ Me	edium 🗆 Deep	
What makes it better? What makes it worse? What makes it worse? What are your goals for this treatment session? Have you had any orthopaedic injuries? yes no If yes, please list: Please indicate any of the following that apply to you. Cancer Fibromyalgia Headaches/Migraines Stroke Arthritis Heart Attack Diabetes Kidney Dysfunction Joint Replacement(s) Blood Clots High/Low Blood Pressure Numbness	Do you suffer from chronic pain? \square yes \square no		Do you have any allergies or ser	nsitivities? 🗆 yes 🗆 no	
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What are your goals for this treatment session? Have you had any orthopaedic injuries?			not want massaged? \square yes \square r	10	
Have you had any orthopaedic injuries?	What makes it worse?		Please explain		
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Please indicate any of the following that apply to you. Cancer Fibromyalgia Headaches/Migraines Stroke Arthritis Heart Attack Diabetes Kidney Dysfunction Joint Replacement(s) Blood Clots High/Low Blood Pressure Numbness	If yes, please list:		Please circle any areas of discor	nfort	
 ☐ Headaches/Migraines ☐ Arthritis ☐ Diabetes ☐ Kidney Dysfunction ☐ Joint Replacement(s) ☐ Blood Clots ☐ High/Low Blood Pressure ☐ Numbness 			R		
 ☐ Headaches/Migraines ☐ Arthritis ☐ Diabetes ☐ Kidney Dysfunction ☐ Joint Replacement(s) ☐ Blood Clots ☐ High/Low Blood Pressure ☐ Numbness 	☐ Cancer	☐ Fibromyalgia		LIVAL LAN	
 □ Diabetes □ Joint Replacement(s) □ Blood Clots □ High/Low Blood Pressure □ Numbness 				1/5-4/7 [4]	
☐ Joint Replacement(s) ☐ Blood Clots ☐ High/Low Blood Pressure ☐ Numbness	☐ Arthritis	☐ Heart Attack			
☐ High/Low Blood Pressure ☐ Numbness	☐ Diabetes		1 /4/14/	\	
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	☐ Neuropathy	☐ Sprains or Strains	F (1)	(V) ~	
Explain any conditions you have marked above: By signing below you agree to the following. I have completed this form to the best of my ability and knowledge and agree in inform my therapist if any of the above information changes at any time.	Explain any conditions you h	ave marked above:	I have completed this form to the best of my ability and knowledge and agree to		
Client Signature Date			Client Signature	Date	