JEFF ROBINSON
REMEDIAL MASSAGE THERAPIST

Client Intake Form

Name: …… Date of Birth: ……..

Address: ……

Phone: …… Health fund: ……...

How did you hear about this clinic? ……..……..……...

Recreational Activities: …… Occupation: ……...

Do you have Doctor/ Health Practitioner: ……....

MEDICAL INFORMATION

Please list any over the counter medication, prescription medication, blood thinning medication or supplements you are taking?

……..……

……..

……..……

……..……

Please indicate if you have or have had any of the following conditions:

☐ Cancer	☐ Fibromyalgia	☐ Headaches	☐ Migraines
☐ Stroke	☐ Arthritis	☐ Heart attack	☐ Stress
☐ Joint replacement	☐ Blood clots	☐ High blood pressure	☐ Low blood pressure
☐ Numbness	☐ Nerve pain	☐ Broken bones	☐ “Herniated” disc

Any other conditions?

……..……

……..

……..……...

Are you pregnant? ☐ Yes ☐ No How many months? ……

Are you sensitive or allergic to fragrances or oils? ☐ Yes ☐ No

MASSAGE HISTORY

Have you had a massage before? ☐ Yes ☐ No

What is the reason for your visit? ☐ Relaxation ☐ Stress ☐ Pain / injury

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INFORMED CONSENT AND CONSENT TO SHARE INFORMATION.

I have provided a detailed medical history to the best of my ability. I do not expect the therapist to have foreseen any previous or pre-existing condition that I have not mentioned.

I also understand that massage therapy may produce side effects such as muscle soreness, mild bruising, increased awareness in areas of pain and lightheadedness amongst other possible outcomes.

I am aware that the therapist does not diagnose illness, prescribe medications or physically manipulate the spine or its immediate articulations.

The therapist understands that I have the right to question any procedures used and to receive an explanation of any procedures that the therapist performs.

I will tell the therapist about any discomfort I may experience during my therapy session and understand that the therapy will be adjusted accordingly.

I understand that all records relating to my treatment will be retained in line with all Australian State and Federal Laws and that I may request a copy of these records at any time. I understand that this information may be shared with my Private Health Fund for the sole purpose of verifying any claim that I make for the service.

Client signature: …… Date: ……...

Therapist signature: …… Date: ……...