Yakseva Intake Form - Therapeutic Massage

# Client Information

Name Click or tap here to enter text. Email Click or tap here to enter text. DOB Click or tap here to enter text.

Phone (cell/day) Click or tap here to enter text. Address Click or tap here to enter text. Postcode Click or tap here to enter text.

Emergency Contact Name Click or tap here to enter text. Phone Number Click or tap here to enter text.

Relationship Click or tap here to enter text. Occupation Click or tap here to enter text.

Referred by: Click or tap here to enter text.

Are you taking any medications?  yes no  If yes, please list Click or tap here to enter text.

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) yes no If yes, please list: Click or tap here to enter text.

Are you pregnant?  yes no If yes, how many months: Click or tap here to enter text. Due date Click or tap here to enter text.

Are you you currently under medical supervision or receiving other medical interventions?  yes  no

If yes, please describe: Click or tap here to enter text.

Areas of swelling Yes  No

Auto immune disorder Yes  No

Back and Neck Problem Yes  No

Bleeding Disorders Yes  No

Blod clots Yes  No

Bruise easily Yes  No

Bursitis Yes  No

Cancer Yes  No

Contagious condtion Yes  No

Decreased sensation Yes  No

Diabetes Yes  No

Fibromyalgia Yes  No

Headaches Yes  No

Heart condition Yes  No

Hypertension Yes  No

Kidney disease Yes  No

Multiple sclerosis Yes  No

Neurological condition Yes  No

Neuropathy Yes  No

Osteoarthritis Yes  No

Osteoporosis Yes  No

Phlebitis Yes  No

Sciatica Yes  No

Seizures Yes  No

Stroke Yes  No

Tendinitis Yes  No

TMJ disorder Yes  No

Varicose veins Yes  No

Vertigo/dizziness Yes  No

Areas of broken skin? (e.g. rash, wounds) yes  no  If yes, where? Click or tap here to enter text.

History of joint replacement surgery? Yes  No  If yes, which joint(s) ? Click or tap here to enter text.

Recent injuries or medical procedures in the past 2 years? Yes  No Please describe: Click or tap here to enter text.

Please describe any other injuries or health conditions: Click or tap here to enter text.

Have you had professional massage before? Yes  No  How recently? Click or tap here to enter text.

Reason for seeking massage:  Relaxation Specific problem

*Please describe any areas of discomfort* Click or tap here to enter text.

How much pressure do you prefer?  Light  Medium  Firm

*By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.*

Client Signature Click or tap here to enter text. Date Click or tap here to enter text.