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.