

INTAKE FORM

LE MANAIA MASSAGE

Please fill out this form before your first appointment. You may either print and bring your filled form to your appointment or email to ambsiu@gmail.com.

PERSONAL INFORMATION

Name _____ Phone _____

Address _____ DOB _____

Email _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____

How did you hear about Le Manaia Massage? _____

MEDICAL INFORMATION

Are you taking any medications? Yes No

If yes, please list names and use: _____

Are you currently pregnant? Yes No

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? Yes No

If yes, please explain _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? Yes No

If yes, please list: _____

Please indicate any of the following that apply to you.

- | | |
|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Sprains or Strains |

Explain any conditions you marked above: _____

MESSAGE INFORMATION

Have you had a professional massage before? Yes No

What type of massage are you seeking?

Relaxation Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

Light Medium Deep

Do you have any allergies or sensitivities? Yes No

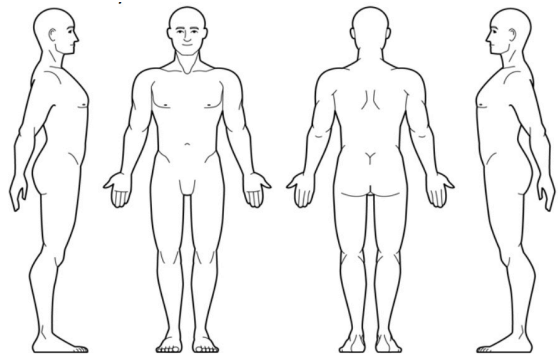
Please explain _____

Are there any areas (feet, face, etc.) you don't want massaged? Yes No

Please explain _____

What are your goals for this treatment session? _____

Please indicate any areas of discomfort



By signing below, you are agreeing to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____

Therapist Signature _____ Date _____