PAINAWAY THERAPY

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New Client Intake Form

NAME:	
ADDRESS:	
PHONE:	
DATE OF BIRTH:	
OCCUPATION:	
EMAIL ADDRESS:	
SPORT/EXERCISE:	
REFERRED BY:	
MASSAGE PRESSURE:	Light / Medium / Firm / Relaxation

Please indicate any areas of pain or discomfort

☐ NECK PAIN	☐ WRIST PAIN	☐ UPPER BACK PAIN	☐ HIP PAIN
☐ JOINT PAIN	☐ ELBOW PAIN	☐ LOWER BACK PAIN	☐ KNEE PAIN
☐ HEADACHES	☐ SHOULDER PAIN	OTHER:	
PLEASE DESCRIBE TYPE OF PAIN/ DISCOMFORT IN EACH AREA	e.g. ache, muscle tightness, shooting pain, pins and needles, numbness		
MEDICATION/ TREATMENT	Any medication/ treatment for an injury?		

Medical History

PLEASE TICK ANY THAT APPLY TO YOU, NOW OR IN THE PAST:	☐ Arthritis ☐ Asthma ☐ Cancer ☐ Cold, Flu or Fever ☐ Diabetes ☐ Dizziness/Fainting ☐ DVT ☐ Eczema ☐ Heart Disease ☐ History of Stroke ☐ Vertigo ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Diagnosed Disc Problems ☐ Sleep disorders ☐ Surgery
ANY OTHER CONDITIONS:	
FEMALE CLIENTS - ARE YOU PREGNANT?	YES / NO If yes, how many weeks _____

Client acknowledgment:

☐ I have advised the practitioner of all existing medical conditions and past/present injuries

☐ I agree to keep the practitioner informed if any new medical conditions/injuries occur in the future

☐ I am happy to receive the occasional email and specials

Client signature _____ Date: _____