Patient Intake Form **Date: _____**

Personal Information

Name: _____ DOB: _____ Age: _____

Address: _____ Gender: M / F

City: _____ State: _____ Post code: _____

Mobile number: _____Email:_____

Occupation/s duties: _____

Were you referred if so who by? _____

Health fund: _____

Emergency contact:

Name: _____ Relationship: _____ Number: _____

Lifestyle

Do you do any recreational Sports/Activities/Exercise? If so how often:_____

What is your dominant hand?..... RIGHT / LEFT

Do you wear Orthotics?..... YES / NO

Medical and Health Information

Allergies? (reactions):_____

Are you or could you be pregnant: YES / NO - Due date:_____
Please note massage is recommended against if you are in the first trimester.

Are you currently on any prescribed /non-prescribed medications or Supplements? YES / NO

Will you have any issue with laying on your side, back or front for the duration of the massage?