INDIAN HEAD MASSAGE - INTAKE FORM

87 Bridge Street West,
Bancroft, ON K0L 1C0

416 837-0031
troymillerrmt@gmail.com

Name ______________________ Date ______________________

Address ______________________ Birth Date ______________________

City ______________________ Postal Code ______________________

Phone ______________________ Email: ______________________

ContraIndications and Precautions

YES	NO	
❏	❏	Any recent head or neck injuries, including whiplash and concussion
❏	❏	Severe bruising in the areas to be treated
❏	❏	Epilepsy
❏	❏	Recent Hemorrhage
❏	❏	High or Low Blood Pressure (unless under control)
❏	❏	Migraine, treatment may result in an attack
❏	❏	A history of Thrombosis or Embolism
❏	❏	Diabetes (unless under control)
❏	❏	Infectious skin disorders
❏	❏	Scalp infections
❏	❏	Cuts or abrasions in the treatment areas
❏	❏	Recent operation
❏	❏	Chronic Fatigue Syndrome
❏	❏	High temperature, illness and fever
❏	❏	Any infectious disease
❏	❏	Intoxication
❏	❏	Aneurism
❏	❏	Food poisoning
❏	❏	Cancer or any other serious medical condition
❏	❏	Osteoporosis
❏	❏	Frailty
❏	❏	Spondylitis or Spondylosis
❏	❏	Other conditions not mentioned above

Do you suffer from any of the following? If yes please indicate severity (1 is mild, 5 is severe)

①②③④⑤ Tension headaches
①②③④⑤ Neck stiffness
①②③④⑤ Shoulder stiffness
①②③④⑤ Eye strain
①②③④⑤ Sinusitis/ Sinus congestion
①②③④⑤ Insomnia/ disturbed sleep
①②③④⑤ Lack of concentration
①②③④⑤ Hair loss
①②③④⑤ Dandruff
①②③④⑤ Premature greying
①②③④⑤ Anxiety
①②③④⑤ Mental tiredness
①②③④⑤ Stress
①②③④⑤ Depression

I certify that the above information is correct to the best of my knowledge. I will not hold the Indian Head Massage Practitioner responsible for any errors or omissions that I have made in the completion of this form. I understand that Indian Head Massage is designed for relaxation purposes only. Information exchanged during any Indian Head Massage session is educational in nature and should be used at your own discretion. All client information is held in strict confidence.

Signature ______________________ Date ______________________