

PATIENT INTAKE FORM: INFORMATION FOR ASSESSMENT AND TREATMENT

PERSONAL INFORMATION

Name _____ Date of Birth: _____ Phone: _____
 Address _____ City/Zip Code _____ Email: _____
 Emergency Contact (name and Phone number)? _____
 Occupation? _____ Whom may we thank for the referral _____

HEALTH INFORMATION

INSURANCE Co. POLICY/CLAIM NUMBER

Primary Care Physician: _____
 First Massage or Body Treatment? yes no
 Preferred Pressure: light medium deep unsure
 Reason for visit _____
 Areas that need attention today? _____
 Any Pain associated? yes no Describe _____
 Please list any surgeries, injuries or accidents and dates: _____
 Medications: _____

BlueCross/Shield _____
MVP-CIGNA _____
AETNA: _____
No Fault: _____

Please check all that apply:

Mark appropriate stress zones

Respiratory

- breathing problem(lung)
- sinus problems
- Allergies

Musculoskeletal

- tendonitis
- Bursitis
- sprains/strains
- broken/fractured bones
- bruise easily
- spasms/cramps
- carpal tunnel
- shoulder/neck problems
- low back pain
- joint pain/degeneration
- jaw pain/TMJ
- sciatica
- arthritis

Nervous System

- herpes/shingles
- numbness/tingling
- chronic pain
- fatigue
- sleep disorder

Mental/Emotional

- suffer from stress
- depression
- anxiety
- insomnia

Circulatory

- heart problems
- varicose veins
- high blood pressure
- arteriosclerosis
- migraines

Skin

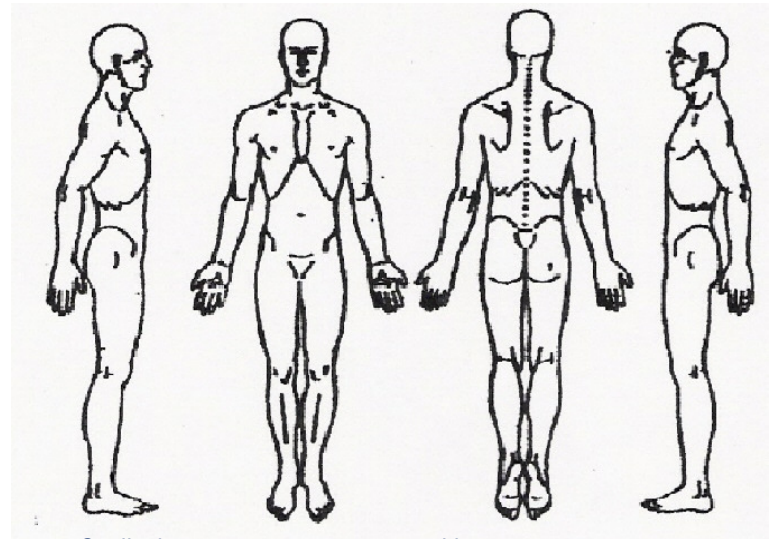
- allergies
- Rashes
- athletes foot
- warts

Reproductive

- pregnant or nursing
- PMS or menopausal
- fibroid tumors

Other

- Fibromyalgia
- Multiple Sclerosis
- Lupus



- Scoliosis
- diarrhea/constipation/IBS
- diabetes
- epilepsy
- cancer
- smoking
- jaundice / hepatitis
- exercise
- contact lenses
- last consumption of alcohol

INFORMED CONSENT

The above information is accurate to the best of my knowledge. I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I understand this does not deter me from seeking medical treatment for medical conditions. I agree to inform the therapist of any experience of pain during the session.

I understand that massage therapy is not a substitute for medical examination, diagnosis and treatment, and that I should see a medical or chiropractic doctor or other health care specialist for those services. Because massage should not be performed under certain circumstances, I agree to update the massage therapist in regard to health changes and I release the massage therapist from any liability if I fail to do so.

PAYMENT/CANCELLATION POLICY

I understand that **twenty-four hour notice must be given** when canceling appointments. I agree to pay for the session when less than twenty-four hour notice is given for non-emergencies. I understand that I am **allowed one no-show visit** and that I must **prepay for all further appointments**.

CLIENT SIGNATURE (BELOW).

DATE

THERAPIST SIGNATURE

DATE