Massage Intake Form

Date: _____

PATIENT INFORMATION

Name _____ Cell Phone # _____

Email _____ Home Phone # _____

Date Of Birth _____ AHC # _____

Address _____ City _____

Family Doctor _____ Postal Code _____

Emergency Contact Name _____ Phone # _____

Referral Source:

☐ Google ☐ Doctor ☐ Social Media ☐ Family/Friend

Whom can we thank for this referral? _____

PRIVATE INSURANCE

Do you have any private insurance / benefits? ☐ Yes ☐ No

Primary Insurance Company: _____ Policy/Group #_____

Insurance Renewal Month: _____ ID #_____

Plan Member Name: _____

DOB of Plan Member: _____ Relationship to Plan Member: _____

Secondary Insurance Company: _____ Policy/Group #_____

Insurance Renewal Month: _____ ID #_____

Plan Member Name: _____

DOB of Plan Member: _____ Relationship to Plan Member: _____

HEALTH & LIFESTYLE INFORMATION

Do any of the following conditions apply to you?

- ☐ Headaches/migraines
- ☐ Osteoporosis
- ☐ Insomnia
- ☐ Inflammatory illness
- ☐ Arthritis
- ☐ Anemia/blood disorders
- ☐ HIV/AIDS
- ☐ TMJ
- ☐ Neurological (i.e. Stroke, Seizures, Epilepsy)
- ☐ Fainting/dizziness
- ☐ Diabetes
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Respiratory problems
- ☐ Anxiety or Depression
- ☐ Cancer
- ☐ Unexplained weight loss/gain.
- ☐ Currently pregnant
- ☐ Cardiac problems (high BP, heart disease, etc.)
- ☐ Other:_____

Please list current medications and their purpose:

_____

_____

List daily activities/hobbies, both sedentary and active, including frequency:

_____

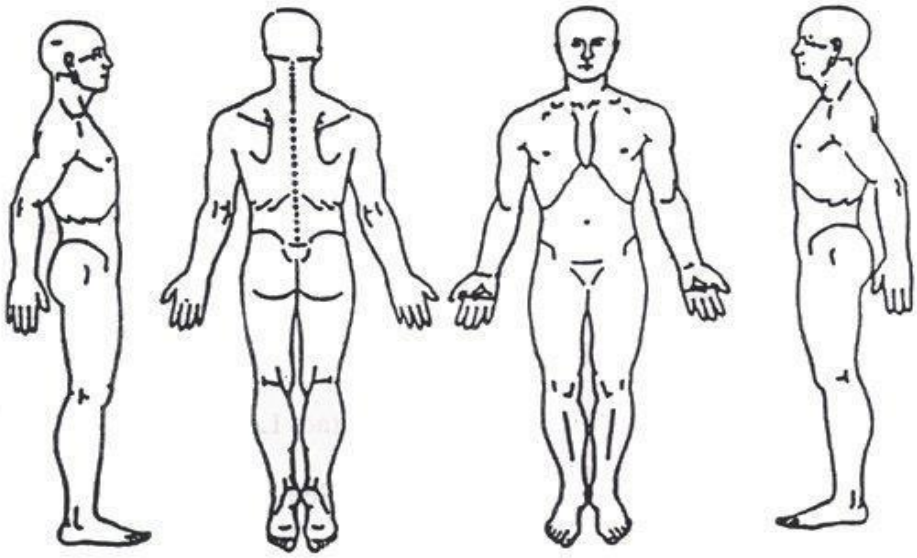
_____

Please list any injuries, accidents or major illness including dates:

_____

_____

Please indicate the areas, if any, where you are feeling discomfort:



When did this start? (Please describe the discomfort: sharp, numb, achy, tingly, shooting, etc.)

_____

_____

What pressure would you prefer?

- ☐ Light
- ☐ Medium
- ☐ Deep

Would you prefer a silent massage or conversation?

- ☐ Conversation
- ☐ Silence

CANCELLATION POLICY & CONSENT

We are here to provide you with the very best care and attention. Your treatment time is reserved just for you. In our commitment to provide an outstanding experience to all our patients and out of consideration for our practitioner's time, we will be enforcing a cancellation and no-show policy. **A minimum of 24 hours is required for cancellations or an initial cancellation/no show fee of $50.00 will be charged to your account. All subsequent cancellations/no shows will result in 100% of the service fee being charged to your account.** As a courtesy to our patients, if you arrive late, your session will be shortened to the remainder of your original scheduled appointment. By signing below, you acknowledge that you have read and understand our policies. Thank you for your understanding.

By signing this, I demonstrate that I:

- **understand the cancellation policy and acknowledge the potential charges for late cancellations or no-shows.**
- **acknowledge that the Registered Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder.**
- **I understand that no assurance or guarantee has been provided to me as to the results of the treatment.**
- **have read this form and give consent to receive massage therapy treatment.**

Patient/ Legal Representative Signature: _____

Name: _____ Dated: _____