



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? _____

HEALTH & LIFESTYLE INFORMATION

Do any of the following conditions apply to you?

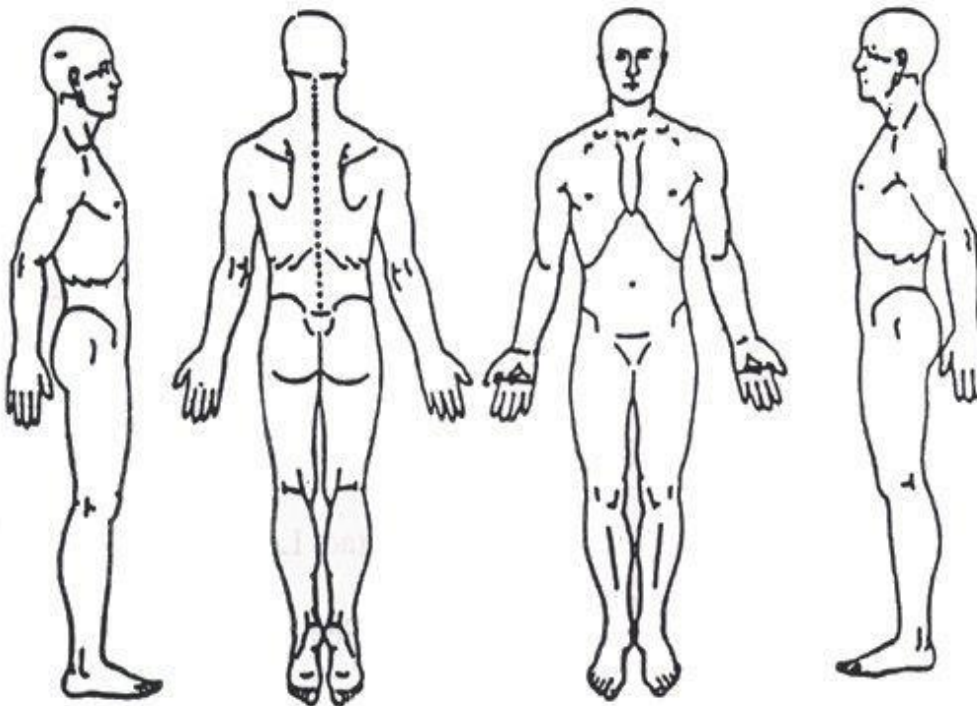
- | | |
|--|---|
| <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Inflammatory illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia/blood disorders |
| <input type="checkbox"/>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

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 100% of the service fee will be 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: _____