MEADOWS MASSAGE

Massage Intake Form

Last Name _____ Hm Phone _____

First Name _____ M.I. _____ Wk Phone_____

Mailing Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email Address _____

Occupation _____ Date of Birth ___/___ /___ Age ____ ❍ Male ❍ Female Marital Status: _____

Injury Treatment? ❍ Yes ❍ No Date of Injury ___/___ /___ ❍ Auto ❍ Work ❍ Other _____

How did you learn about us?_____

Why are you here today for massage? _____

Have you received professional massage before? ❍ Yes ❍ No

If yes, what depth of work did you received? ❍ Light ❍ Medium ❍ Deep ❍ Very Deep

Level of conversation you prefer during your massage: ❍ I love to chat ❍ I lead the conversation ❍ I prefer silence

Health History

Are you currently receiving medical or chiropractic care? ❍ Yes ❍ No

If yes, please explain _____

List current medications and purpose: _____

_____

Mark any condition that applies to you now or in the past. Please use 'C' for current, 'P' for past

___ Allergy to Nut Oils	___ Contagious Conditions	___ Menstrual Pain
___ Arthritis	___ Decreased Sensation / Numb	___ Neck Pain
___ Artificial Joint	___ Diabetes	___ Thrombosis / Embolism
___ Back Pain	___ Fibromyalgia	___ Osteoporosis
___ Blood Clots	___ Headaches / Migraines	___ Pregnant: # wks _____
___ Bruise Easily	___ Heart Attack / Stroke	___ Sciatica
___ Bursitis	___ High Blood Pressure	___ Skin Infections
___ Cancer / Tumor	___ Low Blood Pressure	___ Varicose Veins

Other relevant health history: _____

Accidents, Injuries, or Surgeries:

Less than 5 years ago: _____

More than 5 years ago: _____

Do you exercise? ❍ Yes ❍ No Type? _____ How often? _____

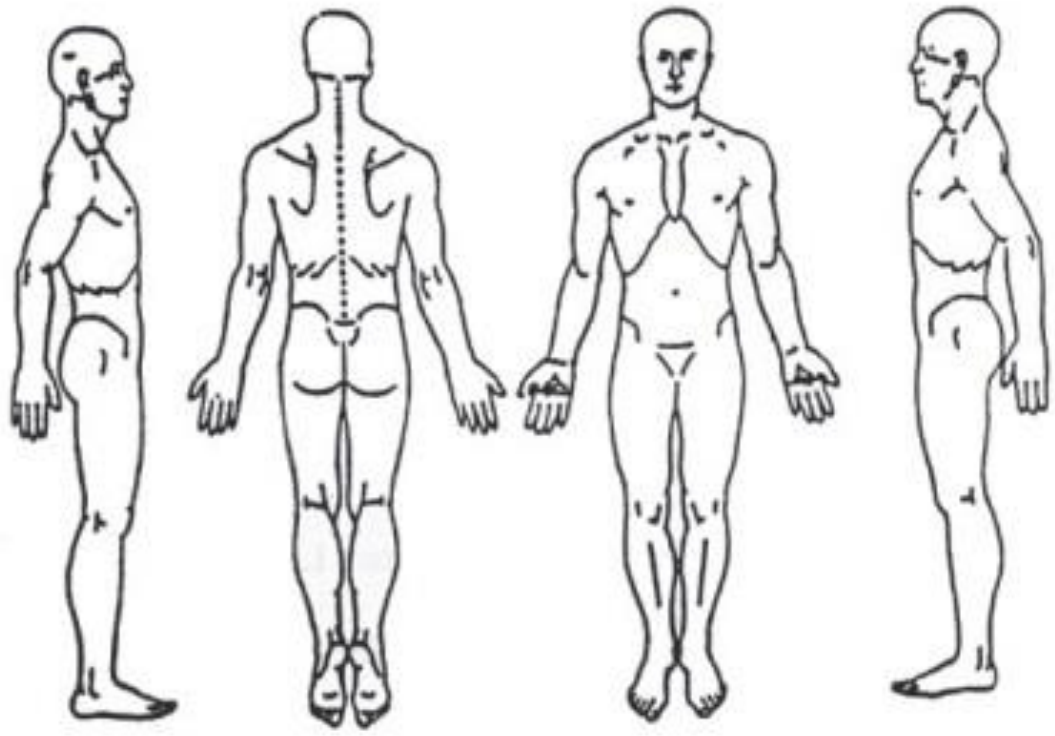
Please READ and INITIAL:

____ Payment is due at the time of service. We accept cash, checks, Visa, MasterCard and American Express.
____ There is a $15.00 charge for returned checks.
____ If the appointment is missed or cancelled without 24-hour notice, **your card on file *will* be charged a $30 fee**.
You may contact us easily by phone, text, or email to inquire about making changes to your scheduled time.
____ Massage therapists do not diagnose illness or disease, or prescribe treatments.
____ All information provided is complete and accurate; I will notify Meadows Massage of any changes.
Any changes in my physical condition will be told to my treating LMP prior to my treatment.
____ We reserve the right to change the terms and conditions at any time.

Patient/Guardian Signature _____ **Date** _____

Circle any areas you would like the massage therapist to ***focus*** on during the massage.

Put an "X" on any areas you would like the therapist to ***avoid***.



Do you have any questions or concerns? _____

_____

_____

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