Massage Intake Form

Name: _____ Date: _____

Address: _____ ZIP _____

Tel: (home) _____ (cell) _____ Date of Birth _____

Occupation: _____ Email: _____

Main Complaint(s):

_____

_____

Motor Vehicle Related? Yes No If Yes, date of accident: _____
Type of Accident? _Rear Impact _Front Impact Side Impact: Left or Right _Pedestrian

List any Accident injuries or surgeries you have experienced: _____

_____

_____

Are you currently attending any of the following:

_ Chiropractor _ Physiotherapy _ Acupuncture _ Other

Please check any conditions that apply:

_ Cancer	_ Epilepsy	_ Allergies
_ Heart Disease	_ Dizziness	_ HIV
_ High Blood Pressure	_ Headaches	_ Chronic Fatigue
_ Low Blood Pressure	_ Hemophilla	_ Fibromyalgia
_ Stroke	_ Arthritis	_ Digestive Disorders
_ Paralysis	_ Hypoglycemia	_ Osteoporosis
_ Diabetes	_ Hepatitis (type) _____	_ Other

If PREGNANT, How many weeks? _____

List all medications: _____

_____

1. I have stated all my known medical conditions. If at any time my health condition changes. I take it upon myself to inform the massage therapist.
2. I understand that payment is expected at the time of my visit unless prior arrangements have been made.
3. I understand that if I do not give 24 hours notice for cancellation of an appointment that I may be charged a cancellation fee of $40.

_____ _____

Date Patient Signature