

MESSAGE INTAKE FORM



Preferred Name (Nickname)

Legal Name (First Middle Last)

Street Address

City

State

Zip code

Phone number

Email address

Birth date

Marital Status

Preferred gender + pronoun

Emergency contact name

Emergency contact relationship

Emergency contact cell phone number

Emergency contact alt phone number

Do you prefer phone or email contact?

Phone

Email

Would you like to be added to our email newsletter list? You can opt out anytime. Yes No

How did you hear about us? _____

Do you have any major medical conditions or that you are currently under treatment for?

Yes No

If yes, please explain below:

Please circle all that apply to your past or current health:

Allergies

Diabetes

Jaw pain/TMJ

Sinus problems

Arthritis

Fatigue

Muscle or joint pain

Skin problems

Blood clots

Headaches

Numbness/tingling

Sleep difficulties

Cancer/Tumors

High/low blood pressure

Painful menstruation

Sprains/strains

Chronic pain

HIV/AIDS

Pregnancy

Tendonitis

Depression

Infectious disease

Scoliosis

Varicose veins

Vision problems

What is the main reason for your visit today?

What are you chiefly hoping to address?

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Is there anywhere you would prefer me **NOT** to massage _____

Are you currently receiving healthcare? Yes No.

If yes, from whom? _____

Have you had any recent hospitalizations or surgeries? Yes No.

For what reason? _____

Do you have any major medical conditions that you are currently under treatment for?

Please list all medication and supplements below:

Medication or Supplement	Dosage	Frequency

Required Insurance Information (if we are billing insurance for your treatment):

Insurance Company	
Subscriber ID#	
Group #	

If you are not the primary subscriber on your insurance, please provide the following information about the PRIMARY SUBSCRIBER:

Full Legal Name	
Address	
Date of Birth	
Gender Designation	
Marital Status	

If we are billing your insurance, please provide a copy of photo identification and your insurance card.