

SAFE HAVEN MASSAGE

CONFIDENTIAL MASSAGE CLIENT INTAKE FORM

Personal Information

Name _____ Date _____
Street _____ City _____ Zip _____
Home Phone _____ Work/Cell Phone _____
Occupation _____ Date of Birth _____
Emergency Contact _____ Phone _____
Referred by _____ Email address: _____

Insurance Information (only if massage is being billed to insurance)

Primary Care Provider or Referring Physician _____
Insurance Company Name _____
ID/Policy Number _____ Group/Claim Number _____
Date of Loss or Accident _____ Claim Number _____
Name of Primary Insured _____

I agree to the release of information for medical or insurance purposes.
I authorize Leah Bowman, L.M.P. to obtain information from my primary care providers concerning my health pertinent to the condition she is treating me for . Yes / No Please initial here if Yes _____

Message History and Treatment Information

Have you ever had a professional massage before? _____ If so, how often? _____

What is the main reason for this visit? _____

Please check the areas of your body that you give permission to receive massage.

back legs feet arms hands neck head face chest abdomen buttocks

Daily Water Intake? (Please circle) 8+ glasses 6-8 glasses 4-6 glasses 2-4 glasses 0-2 glasses

Caffeine Intake? (Please circle) Never Occasionally Daily If Daily, how much? _____

Please list any medications you are currently taking (including over the counter and herbal remedies) _____

How often do you exercise? _____

Are you currently receiving treatment from a medical practitioner, chiropractor or physical therapist? _____

If yes, please explain _____

Are you currently experiencing any of the following conditions?

Fever _____ Flu/Cold _____ Infection _____

Contagious Disease or skin condition _____

Numbness or Tingling _____ If yes, where? _____

Swelling/Inflammation _____ If yes, where? _____

Health History:

(please include approximate date)

Surgeries: _____

Major illnesses or hospitalizations: _____

Injuries/accidents still affecting you: _____

Please mark any of the following conditions you are currently dealing with or have dealt with in the past. Mark with an **C** for Current and a **P** for Past. Please use the space next to each item for explanations or details if applicable. **Leave blank if it does not apply to you.**

___ tendonitis _____

___ bursitis _____

___ arthritis _____

___ broken bones _____

___ osteoporosis _____

___ sprains/strains _____

___ carpal tunnel syndrome _____

___ disc problems _____

___ whiplash _____

___ chronic tension headaches _____

___ migraines _____

___ head injuries _____

___ jaw pain/TMJ _____

___ heart condition _____

___ blood clots _____

___ varicose veins _____

___ high or low blood pressure _____

___ sinus problems _____

___ allergies _____

___ asthma _____

___ emphysema _____

___ other _____

___ rashes _____

___ athletes foot _____

___ psoriasis/eczema _____

___ ulcers _____

___ irritable bowel syndrome _____

___ chronic constipation _____

___ kidney infections/disease _____

___ crohn's/colitis _____

___ fibromyalgia _____

___ cancer/tumors _____

___ stroke _____

___ diabetes _____

___ hepatitis C _____

___ chronic fatigue _____

___ insomnia _____

___ depression _____

___ anxiety _____

For Women Only:

___ endometriosis _____

___ Fibroids _____

Are you or could you be Pregnant? _____

If YES, How Many Weeks ? _____

I have read the above information and discussed it with my massage therapist. I understand that massage therapists do not diagnose illness or any physical or mental condition, nor prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I have stated all medical conditions that I am aware of and will update my therapist of any changes in my health status.

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, increasing circulation or energy flow and relief from muscular tension or pain.

I understand that massage therapy treatments are my personal financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made.

Signed _____ Date _____