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 _____

Massage 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 _____