Advanced Medical Massage NW

450 Port Orchard Blvd Suite 390

Port Orchard, WA 98366

Office: 360-440-8060

Fax: 360-602-0895

 **MASSAGE PATIENT INTAKE FORM**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (street) (city) (state) (zip code)

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you to us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced any of the following conditions? If so, please mark month/year of onset.

\_\_\_\_\_ AIDS \_\_\_\_\_ Edema \_\_\_\_\_ Sciatica

\_\_\_\_\_ Allergies \_\_\_\_\_ Epilepsy/Seizures \_\_\_\_\_ Stiff Joints

\_\_\_\_\_ Anemia \_\_\_\_\_ Eczema \_\_\_\_\_ Skin Allergies

\_\_\_\_\_ Arthritis \_\_\_\_\_ Headaches \_\_\_\_\_ Strain/Sprain

\_\_\_\_\_ Athlete’s Foot \_\_\_\_\_ Heart Attack or Ailments \_\_\_\_\_ Excess Stress

\_\_\_\_\_ Back Pain \_\_\_\_\_ Hemophilia \_\_\_\_\_ Stroke

\_\_\_\_\_ Broken Bones \_\_\_\_\_ Herpes Virus \_\_\_\_\_ Tendonitis

\_\_\_\_\_ Bursitis \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Tingling \_\_\_\_\_ Cancer \_\_\_\_\_ Insomnia \_\_\_\_\_ Tumors

\_\_\_\_\_ Circulation Problems \_\_\_\_\_ Low Blood Pressure \_\_\_\_\_ Varicose Viens

\_\_\_\_\_ Colitis \_\_\_\_\_ Migraines \_\_\_\_\_ Whiplash

\_\_\_\_\_ Constipation \_\_\_\_\_ Muscle Spasms

\_\_\_\_\_ Diarrhea \_\_\_\_\_ Numbness For women only:

\_\_\_\_\_ Diabetes \_\_\_\_\_ Phlebitis \_\_\_\_\_ Menstrual Cramps

\_\_\_\_\_ Digestive Problems \_\_\_\_\_ Psoriasis \_\_\_\_\_ Excessive Bleeding

\_\_\_\_\_ Disc Problems \_\_\_\_\_ Rashes \_\_\_\_\_ Lack of Periods

\_\_\_\_\_ Diverticulitis \_\_\_\_\_ Ringworm \_\_\_\_\_ PMS

COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Accidents Injuries or Surgeries:**

MORE than 5 years ago: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LESS than 5 years ago: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you receiving medical or chiropractic care: **□** Y **□** N

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medication? **□** Y **□** N If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing any of the following conditions?

\_\_\_\_\_ Pregnancy \_\_\_\_\_ Flu or Cold \_\_\_\_\_ Infection

\_\_\_\_\_ Inflammation \_\_\_\_\_ Fever \_\_\_\_\_ Contagious Disease

Do you smoke? **□** Y **□** N If so, are you willing to refrain from smoking prior to your massage appointments? **□** Y **□** N

Any dietary restrictions? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any sleep difficulties? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses? **□** Y **□** N

How often do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water do you drink daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where do you tend to hold stress in your body? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any especially tender-to-touch areas? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received massage before? \_\_\_\_\_\_\_\_\_\_ Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why have you come for a massage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am aware of and agree to honor the “no show” policy by paying in full (ie.$65.00 for a one hour massage appointment, $95.00 for a 1.5 hour massage appointment, plus a $15.00 billing fee per month and 3% interest per month for any outstanding balance due) for any missed or cancelled appointments with less than a 24-hour notice given to Advanced Medical Massage NW. Emergency circumstances will be considered individually.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Patient signature) (Date)