providence
Apothecary & Holistic Center

Massage Intake Form - CONFIDENTIAL INFORMATION

WELCOME! We would like to make your appointment as pleasant and comfortable as possible. If, at any time, you have questions regarding your session, please let us know.

Name _____ Date of birth ____/____/_____

Address_____ City _____ State _____ Zip _____

Home Phone (____)-_____ Cell Phone (____)-_____

E-mail address _____ Newsletter signup? (circle one): Yes No

How did you hear about us? _____

Occupation _____

Have you ever received massage therapy? (circle one): Yes No

Are you currently taking any medications? (circle one): Yes No

If yes, please list name and reason for medications: _____

_____

Are you currently seeing a healthcare professional? (circle one): Yes No

If yes, please list names and reason/treatment: _____

_____

Please review this list and check those conditions that have affected your health either currently or in the past. Place a check mark next to the condition.

____arthritis
____diabetes
____blood clots
____broken/dislocated bones
____bruise easily
____cancer
____chronic pain
____constipation/diarrhea
____auto-immune condition*
____hepatitis (A, B, C, other)
____skin conditions
____stroke
____surgery
____TMJ disorder

____ depression, panic disorder condition
____ diverticulitis
____ headaches
____ heart conditions
____ back problems
____ high blood pressure
____ insomnia
____ muscle strain/sprain
____ pregnancy (if so, how far along are you? _____)
____ scoliosis
____ seizures
____ whiplash
____ chemical dependency (alcohol, drugs)

(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so:

_____

_____

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Do you have any of the following today:

_____skin rash _____cold/flu _____open cuts
_____severe pain _____anything contagious _____injuries/bruises

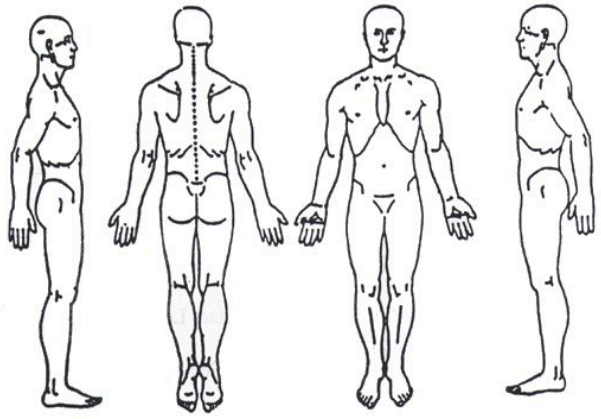
Do you have any allergies to:

_____medications _____foods (nuts, etc.) _____environmental allergens (dust, pollen, fragrances)
_____reactions to skin care products

If any of the above are checked, please give details: _____
_____

Are you wearing: _____contact lenses _____hearing aid _____hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



What are your goals/expectations for this therapy session? _____

_____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to: •need to move or change position •sighing, yawning, change in breathing •stomach gurgling •emotional feelings and/or expression •movement of intestinal gas •energy shifts •falling asleep •memories

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
4. I am aware that appointment cancellations need to be made prior to 24 hours before the appointment start time. Failure to cancel within the 24 hour period can result in late-cancellation fees.

Signature: _____ Date _____/_____/_____