The Wellness Centre

Confidential intake form

Name _____Referred by_____

Address_____

City_____State_____Zip _____

Home #_____Cell #_____

E-Mail_____

Date of birth _____

Primary physician_____ Phone #_____

Reason for appointment today

_____

Are you currently experiencing limitations in your daily living?

Yes ☐ No ☐

(If yes, please explain) _____

Have you ever received professional massage/bodywork before?
Yes ☐ No ☐

Last Massage/bodywork _____

What is your daily water intake? Less than 64oz. ☐ More than 64oz. ☐

Are you currently hydrated? Yes ☐ No ☐

Type of massage preferred: (please check)

☐ **Swedish Massage** (general wellness massage intended to relax the entire body)
☐ **Medical Massage** (muscle treatment for pain reduction and improved function)
☐ **Deep tissue/Relaxation** (to reduce muscle tension and de-stress)

Pressure preferred? ☐ Light ☐ Moderate ☐ Firm

Is there a particular area of the body where you are experiencing stiffness, pain or discomfort? Yes ☐ No ☐
(If yes, please explain)_____

Please check any of the following conditions that apply or have applied to you:
☐ accident ☐ arthritis ☐ fainting spells ☐ fibromyalgia ☐ edema ☐ cold feet

☐ cold hands ☐ sciatica ☐ ringing ears ☐ cancer ☐ skin disorders

☐headaches ☐ high blood pressure ☐ blood clots ☐ varicose veins ☐ vertigo

☐ arthritis ☐ broken bones ☐ feet numb/tingling ☐ hands numb/tingling

☐ shoulder pain ☐ decreased range of motion ☐ joint pain ☐ diabetes ☐ fatigue

☐ low blood pressure ☐ heart problems ☐ chest pain ☐ neck pain ☐ back pain

☐ sinusitis ☐ HIV ☐ shortness of breath ☐ surgery

☐ Other(please explain)_____

Do you have any of the following today: (please check)

☐ inflammation ☐ irritated skin rash ☐ poison ivy ☐ open cuts

☐ bruises ☐ burns ☐ headache ☐ fever ☐sunburn ☐ cold/flu ☐ severe pain

Are you currently under Doctors' care? Yes ☐ No (If yes please explain)
_____

Please read the following and sign below

I understand that this massage is not a replacement for medical care and that no diagnosis will be made. I am also aware there may be some discomfort, soreness, or discoloration that may occur during and/or after today's treatment.
I am responsible for any unpaid balances, deductibles and/or co-pays.

Cancellation Policy

24 hour notice is required to avoid being charged for your scheduled massage session.

Signature _____

Date _____