Green Room Wellness Center Intake Form

Identification Information:

Name____Date:_________________________________

Phone (home/cell)________________________________
Email____

Address
____City__________________________State_______Zip_________________

Date of Birth/age__________________ Male___ Female____ Primary Care Physician:________________________________

Occupation/Frequent activities
____

____

All of the information provided will remain strictly confidential. For certain medical conditions or symptoms massage may be contraindicated. In such cases a referral from your primary care provider may be warranted.

Medical/Health Information:

Have you had therapeutic massage treatment in the past? Yes/No
When?____

Did you find this treatment beneficial? In what way?____

____

What do you hope to gain from treatment?

Short term:____

Long term:____

What other relevant treatments are you receiving and what form (acupuncture, physical therapy, chiropractic, other?)

____

Please list physical activities that you participate in regularly____

____

List previous injuries/illness's that may be still affecting you (add any addtl info on back): _____________________________

____

How would you rate your overall health? ______Excellent_______Good________Fair________Poor

Circle the following symptoms or conditions you have now or have had previously:

Allergies	heart disease/heart attack	poor circulation	lumps in breast/chest	blood clots
Arthritis	high blood pressure	shoulder pain	mammary fibrocysts	muscle/joint pain
cancer	low back pain	skin problems	menopausal symptoms	vision problems
diabetes	multiple sclerosis	stroke	premenstrual symptoms	chronic pain
dizziness	neck pain	tuberculosis	pregnant currently	sinus problems
epilepsy	nervousness/depression	ulcers	recent births	numbness/tingling
Fibromyalgia	numbness	varicose veins	digestive disturbances	fatigue
Headaches	edema (swelling)	polio	infectious disease	alcohol/drug dependency

How did you hear about me?
____

Any other information you would like to include that you feel will be helpful? ______________________________

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Cancellation Policy agreement:

I agree to cancel at least 24 hrs in advance of my scheduled appointment time, so that Kimber can schedule someone else in my slot. If I am unable to do so, I will compensate Kimber Green Massage 50% of current rate of scheduled appt fee. __________(Initial if agree)

Informed Consent: I understand that massage therapy is not intended to be a substitute for proper medical counseling. My massage therapist has not expressed or implied that massage is the primary treatment for any specific illness or disease. I understand that massage is an adjunctive therapy that can be coordinated with the advice, treatment, or prescriptions recommended by my regular physician. The decision to receive massage is left to my own discretion.

I recognize that there is a close working partnership between my practitioner and myself. My ability to share my ideas, perceptions and opinions will facilitate my healing and enhance my experience. This is a partnership.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Signature ____ Date ____________________

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