Good Medicine Massage LLC

Therapeutic Massage for Pain Management • Stress Relief • Relaxation

Jennifer Wayland
303.725.7242

Health History Intake Form

Name ______________________ Date of Initial Visit ______________________

Address ______________________ City, State, Zip ______________________

Home Phone ______________________ Daytime Phone ______________________

Date of Birth ______________________ Age ________ Occupation ______________________

Name of Physician ______________________ Phone ______________________

Emergency Contact ______________________ Phone ______________________

Referred By ____

What is your reason for seeking massage therapy? (relaxation, resolve pain/injury issues, etc.)

____

____

Have you ever received professional massage? __________ If so, how recently? ______________

Check if you wear ( ) contact lenses ( ) dentures ( ) hearing aid ( ) other (specify) __________

Do you have any allergies to oils, lotions, ointments, liniments, etc. put on your skin? **Yes** **No**

If Yes, Please Describe ____

Do you have tension, soreness or other discomfort in any specific area (numbness, etc)? **Yes** **No**

If Yes, Please Describe ____

Do you perform any repetitive movement in your work, sports or hobbies? **Yes** **No**

If Yes, Please Describe ____

Do you sit for long hours at a computer, workstation or driving? **Yes** **No**

If Yes, Please Describe ____

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Do you have any medical condition(s) or are you taking any medications? **Yes** **No**

If Yes, Please Describe ______________________________

Do you have high blood pressure? **Yes** **No**

If Yes, Please List Medications You Are Taking ______________________________

Have you been in an accident or suffered any injuries in the past 2 years? **Yes** **No**

If Yes, Please Describe ______________________________

Have you had any surgery in the past 5 years? **Yes** **No**

If Yes, Please Describe ______________________________

Please describe any other major surgeries, accidents or illness in your history.

____

____

For Women: Are you pregnant? **Yes** **No**

If Yes, How Far Along ______________________________

Please check any of the following that apply to your current health:

__ arthritis/joint issue	___ osteoporosis	___ vericose veins	___ diabetes	___ blood clots
__ heart condition	___ circulatory condition	___ frequent headaches	___ epilepsy/seizures	___ cancer
__ bruise easily	___ lymphatic condition	___ infections	___ any contagious disease	

Comments/Details (If Applicable)

____

____

Has a physician/health care provider recommended massage for any of the conditions above? **Yes** **No**

If Yes, Please Describe ______________________________

Do you experience stress in your work, family or other aspect of your life? **Yes** **No**

How would you describe your stress level? **Low** **Medium** **High** **Very High**

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Please describe any exercise/stress reduction activities you practice regularly.

____

____

How Much Water Do You Drink? ____

Please describe anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you.

____

____

____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage therapy may be contradicted. A referral from your primary care provider may be required prior to service being provided.

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I also understand that any illicit, inappropriate or suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status.

Signature ____________________________________ Date ________________________

Consent to treatment for a minor

By my signature below, I hereby authorize ________________________ to administer massage therapy to my child or dependent as they deem necessary.

Signature ____________________________________ Date ________________________

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Office Policies

Although it is rare to have to exercise the rules and regulations, there are a few. This helps to keep the relationship between therapist and client as professional and therapeutic as possible.

Cancellation

If you should need to cancel or reschedule your appointment, a 48 hours notice is preferred. A 24 hour notice is required in order to avoid a $40 cancellation fee. Payment is due before your next appointment.

***** A NO-CALL, NO-SHOW WILL BE CHARGED THE FULL AMOUNT OF THE SESSION. PAYMENT WILL BE DUE BEFORE YOUR NEXT SESSION. *****

Tardiness

Appointment times are as scheduled and cannot be extended beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Sickness

Massage is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of any infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

***** PLEASE UNDERSTAND THIS POLICY IS IMPLEMENTED TO HELP COVER THE COST OF ANY OTHER PAYING CLIENTS THAT MAY HAVE BEEN TURNED AWAY WHEN AN APPOINTMENT HAD BEEN HELD FOR YOU. *****

Your signature below signifies acceptance of these policies.

Client Name (printed) ____

Date ____

Signature ____