



Patient Information

Contact Information

Name _____ Preferred Name _____

Email address _____ Pronouns _____

Primary Phone Number (_____) _____ Mobile Home Work

Additional Phone Number (_____) _____ Mobile Home Work

Address _____

City _____ State _____ Zip Code _____

Sex Male Female Gender _____ Birth Date ____ / ____ / ____ Age ____

If a minor, Parent/Guardian Name(s) _____

Parent/Guardian Phone _____ Email _____

Marital Status Single Married Divorced Widow Number of Children _____

Occupation _____ Employer/School _____

Work/Student Status Full time Part time

Preferred Appointment Reminder Notification Method(s) Email Text Both

How did you hear about us? _____



Massage Therapy Intake

Patient Name _____ Today's Date _____

Medical Information

Are you taking any medications? No Yes, _____

Are you currently pregnant? No Yes: How far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? No Yes, _____

Have you had any recent surgeries? No Yes, _____

Have you had any orthopedic injuries? No Yes, _____

Please mark any of the following that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Replacement(s) | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> High/low Blood Pressure | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Dysfunction |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Numbness | |

Explain any conditions above: _____

Massage Information

Have you ever had a professional massage? No Yes, _____

What type of massage are you wanting? Relaxation Therapeutic/Deep Tissue
 Other _____

What type of pressure do you prefer? Light Medium Firm/Deep

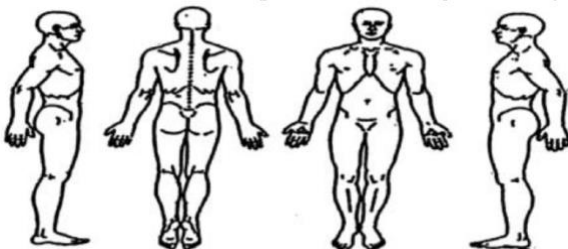
Do you have any allergies or sensitivities? No Yes, _____

Are there any areas (feet, face, abdomen, etc) that you do not want massaged?
 No Yes, _____

Please mark any of the following you would like in your massage:

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Hot Stones | <input type="checkbox"/> Essential Oils |
| <input type="checkbox"/> Cupping | <input type="checkbox"/> CBD Oil |

Please mark any areas of discomfort:



Anything else pertinent to your visit today? _____



**Payment Information & Agreement
Massage and Acupuncture**

Patient Name _____ Date _____

Cancellation and Missed Appointment Policy

We kindly ask that you provide **at least 24 hours' notice** for any cancellation or rescheduling of massage or acupuncture appointments.

Appointments that are **missed or canceled with less than 24 hours' notice** will incur at **\$50 fee**. If a **credit card is on file**, the fee will be automatically charged. If **no card is on file**, you are still responsible for the fee and **prompt payment is expected**.

This policy is in place out of respect for our therapists' time and to allow other patients the opportunity to be seen. We appreciate your understanding.

By signing below, I acknowledge that I have read and understand the above policy, and I agree to pay the \$50 fee in accordance with this cancellation policy, whether or not a card is on file.

Patient Initials

Credit Card on File Authorization

Card Number _____

Expiration Date _____ Security Code _____ Zip Code _____

While keeping a credit card on file is **not required**, it is **highly encouraged** for your convenience. Please indicate your preferred method of handling charges:

- Please charge my card for any and all charges.**

I authorize automatic charges to my card on file for all services rendered.

- Do not charge my card on file.**

I understand I am responsible for all balances and will pay by another method upon receiving a statement.

Patient Initials